Mount Sinai

PLACE LABEL HERE

AUTHORIZATIONS AND ASSIGNMENTS

1. FINANCIAL AGREEMENT/GUARANTEE OF PAYMENT (All Patients)

In consideration of services, assignment of benefits and care rendered; I agree that I am responsible for any and all charges billed by **Mount Sinai Doctors** ("Mount Sinai") with respect to such services and care unless the contract between Mount Sinai and my insurance company provides otherwise and/or unless otherwise provided by law. In the event that the requested services are not specifically authorized by my insurance company, I agree to pay for all services as agreed upon, unless otherwise provided by law.

I authorize payment of medical benefits to which I am entitled directly to Mount Sinai, to cover the cost of the care and treatment rendered to myself or my dependents in the hospital.

Upon receipt of a Mount Sinai bill, I agree to immediately pay all amounts not covered by insurance unless otherwise provided by law. If any insurance I have rejects my claim or pays part of the claim, I shall be responsible for payment of any balance as determined by Mount Sinai immediately upon learning of such coverage, unless otherwise provided by law.

2. RELEASE OF INFORMATION

In the event my insurer denies payment to Mount Sinai for services rendered to me, I hereby give my consent to have an authorized representative of Mount Sinai contact my insurer and to provide to my insurer all information and documentation regarding the services rendered to me by Mount Sinai which may be required in order for my insurer to reevaluate its decision to deny payment for such services.

I authorize Mount Sinai, my treating physician, and their respective designees to use and disclose my health information for all necessary treatment, payment and health care operations purposes. I acknowledge that my health information may include information relating to mental illness and/or AIDS/ARC/HIV and that any such information may be disclosed (including examination and copying in either hard copy or digital format) to insurers, various credit agencies and guarantors solely if needed for payment of Mount Sinai charges and/or professional charges (no clinical information will be disclosed to any credit agency).

3. MEDICARE-RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS (Medicare only Part A and Part B providers)

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers any information (including information relating to mental illness and/or AIDS/ARC/HIV) needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable to physician (s) and/or Mount Sinai Services to the physician (s) or organizations providing the service (s)

4. INSURANCE NETWORK/PROVIDER NOTICE PURSUANT TO NYS "OUT-OF-NETWORK" LAW

I understand that Mount Sinai is a participating provider in many health plan networks, and that a list of the plans that Mount Sinai participates in can be found at www.mountsinaihealth.org/insuranceinfo

I understand that physicians and other providers who render services at Mount Sinai may be employed or contracted by Mount Sinai, or may be independent practitioners who are **not** employed or contracted by Mount Sinai. I further understand that charges for physicians' and providers' "professional services" that I receive at Mount Sinai are **not** included in Mount Sinai's charges, and that physicians/providers may bill for their "professional services" separately from Mount Sinai.

I understand that physicians who provide services at Mount Sinai may not participate in the same health plans as Mount Sinai (even if they are employed or contracted by Mount Sinai). I understand that I can determine the health plans participated in by the physicians who are employed or contracted by Mount Sinai to provide hospital services by visiting http://www.mountsinaihealth.org/insuranceinfo.

I understand that I can check with the physician(s) arranging for my hospital services to determine: (1) the name, practice name, mailing address and telephone number of any other physician/practice whose services will be arranged by the physician; and (2) whether the services of physicians who are employed or contracted by Mount Sinai to provide services (including anesthesiology, pathology and/or radiology) are reasonably anticipated to be provided to me. I further understand that I can determine the health care plans participated in by physicians/practices who are reasonably anticipated to provide services to me at Mount Sinai who are employees of or are contracted by Mount Sinai to provide such services (including anesthesiology, radiology, and/or pathology) by visiting http://www.mountsinaihealth.org/insuranceinfo. I further understand that I can check with the physician(s) arranging for my hospital services to obtain the contact information for any physicians/practices whose services may be needed in connection with my hospital care, and that I can contact those physicians/practices directly to obtain information regarding their health plan participation.

5. Patient Consent to the Release of Records for NYS External Appeal

The patient, the patient's designee, and the patient's provider have a right to an external appeal of certain adverse determinations made by health plans. In the event an external appeal is filed, consent to the release of medical records, signed and dated by the patient, is necessary. An external appeal agent assigned by the New York State Department of Financial Services will use this consent to obtain medical information from the patient's health plan and health care providers. The name and address of the external appeal agent will be provided with the request for medical information.

I authorize my health plan and providers to release all relevant medical or treatment records related to the external appeal, including any HIV-related information, mental health treatment information, or alcohol/substance abuse treatment information, to the external appeal agent. I understand the external appeal agent will use this information solely to make a decision on the appeal and the information will be kept confidential and not released to anyone else. This release is valid for one year. I may revoke my consent at any time, except to the extent that action has been taken in reliance on it, by contacting the New York State Department of Financial Services, in writing. I understand that my health plan cannot condition treatment, enrollment, eligibility, or payment on whether I sign this form. I acknowledge that the decision of the external appeal agent is binding. I agree not to commence a legal proceeding against the external appeal agent to review the agent's decision; provided, however, this shall not limit my right to bring an action against the external appeal agent for damages for bad faith or gross negligence, or to bring action against my health plan

6. Patient Consent for Examination and Treatment

I, the undersigned, hereby authorize and request Mount Sinai to provide such medical care and to administer such diagnostic, radiological and/or therapeutic procedures and treatments; including but not limited to the administration of pharmaceutical products, injection, and intravenous medication or other therapeutic solutions as in the judgment of the physicians treating the patient named on this page may be deemed necessary or advisable.

I HAVE READ, UNDERSTAND AND AGREE WITH THE ABOVE ITEMS.

X _____ _____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE DATED

_____ _____

RELATIONSHIP TO PATIENT WITNESS TO SIGNATURE

A patient under the age of 18 is emancipated and may sign consent for treatment if at least one of the following conditions has been met (circle any which apply):

- The patient is legally married
- The patient is or has been a parent
- The patient is self-supporting and does not reside with parents

A patient under the age of 18 may sign consent to treatment for venereal disease, abortion, and other related gynecologic and obstetric care.

Mount
Sinai
Beth Israel

Name:
DOB:
MR#:

INFECTIOUS DISEASES SCREENING TOOL

ASK these questions to ALL patients:

1. Do you have a fever (T> 38 C (100.4 °F)) or feel hot? ☐ YES ☐ NO
2. Do you have a cough or a sore throat? ☐ YES ☐ NO
3. Are you vomiting or having diarrhea? ☐ YES ☐ NO
4. Do you have a rash? ☐ YES ☐ NO
5. Have you traveled outside the U.S. in the past 30 days? ☐ YES ☐ NO

If yes, where did you travel? _____

Mount
Sinai
Beth Israel

Mount Sinai Doctors Senior Health
Division of Geriatrics
275 8th Avenue
New York, NY 10011
212-463-0101
212-463-0952 (fax)

Name of Patient: _____

Date of Birth: _____

_____
Office/ Facility

_____
Address

_____
Phones

_____
Fax

To Whom It May Concern:

The above named, presently a patient at Beth Israel Senior Health has indicated that he/she is also known to your office or facility. I would appreciate the following information:

____ Initial Evaluation ____ Lab Reports ____ Consultation Reports

____ Progress Notes ____ X-Ray Reports ____ Discharge Summary

____ Other Records: _____

Please return this form with the requested records:

____ Please send records to my attention at
Beth Israel Senior Health Center
275 8th Avenue
New York, NY 10011

____ Please fax records to my attention at
____ 212-463-0952
____ 212-206-8967

Joyce Fogel, MD ☐
Karen Levine-Tanco, MD ☐
Su Aung, MD ☐

Denise Fernandes, MD ☐
Anthony Dunzeli, MD ☐
Danielle DeMerieux ☐

Very truly yours,

_____
Provider's Signature

_____
Date

To Whom It May Concern:
I hereby authorize you to release to Beth Israel Senior Health Center and its associated provider's any and all information pertaining to my medical history and treatment.

X_____
Patient's Signature

_____
Signature of HCP/Next-of-kin

Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here _____ I authorize _____
Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

X _____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**