Dear, patient:

You are scheduled for an appointment with the Irving Radiation Oncology Department.

Your appointment is scheduled for:

Date: ____________________________  Time: ____________________________

Doctor: ____________________________

*Please arrive 30 minutes early for your appointment to complete the registration process.

Please check-in at:
New York Presbyterian Columbia University Medical Center
Department of Radiation Oncology
622 West 168th Street, Basement Level New York, NY 10032
(Attached to this email is Map of the hospital as a guide to our facility and Information about paying for your care)

PLEASE BRING THE FOLLOWING WITH YOU TO YOUR APPOINTMENT:
(Please do not forward the forms to this email)

☐ Insurance card(s)
☐ Valid photo ID
☐ Completed forms listed below (attached):

1. Medication Reconciliation Form (Please list all medications you are currently taking as well as any allergies)
2. Medical History Form/Review of Systems Form (Please complete both pages)
3. Medical History Form (Please complete form)
4. Columbia University and New York Presbyterian Notice of Privacy Practices (Please read through both and sign both acknowledgements)
5. Authorization of Disclosed Protected Health Information/Medical Records form (Make sure to sign the form as we may need to request your medical records)

If you have any questions or need to cancel/change your appointment, please call us at (212) 305-7077.
HOW TO FIND RADIATION ONCOLOGY AT NEW YORK-PRESBYTERIAN/COLUMBIA UNIVERSITY MEDICAL CENTER

Note: The Broadway Emergency Department entrance is closed.

A Entering from the Harkness Pavilion on Fort Washington Ave. Go through Security. Take the elevator to level 1. Walk toward the Presbyterian Building. Find the sign for Radiation Oncology and make a right towards the Chapel. Make a left and take the Radiation Oncology Elevators down to the department.

B Entering from West 168th Street. Go through Security. Walk past the Presbyterian Elevators and go straight through the intersection towards the Chapel. Make a left and take the Radiation Oncology Elevators down to the department.

C Entering from Broadway and corner of West 165th St. Go through Security. Walk through the Children's Hospital toward the Presbyterian intersection. Find the sign for Radiation Oncology and make a left towards the Chapel. Make another left and take the Radiation Oncology Elevators down to the department.
MEDICATION RECONCILIATION FORM

1. Do you have any allergies to food or medication?
   (¿Tiene alergia a algún alimento o medicamento?)

   □ Yes (Si)  □ No

   If yes, please list them and describe the allergic reactions:
   (Si es sí, por favor póngalos en la lista y describa las reacciones alérgicas):

   __________________________

   __________________________

2. Are you currently taking any medications?
   (¿Está usted tomando algún medicamento?)

   □ Yes (Si)  □ No

   If yes, please list them (Si es sí, por favor de listarlos):

<table>
<thead>
<tr>
<th>Name of Drug (Nombre de Medicina)</th>
<th>Dosage/Strength (Dosis/Fuerza)</th>
<th>How many times a day? (¿Cuántas veces al día?)</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

   REVIEWED BY: ___________________________ DATE: ___________________________
## Medical History/Review of Systems

<table>
<thead>
<tr>
<th>General</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Have you experienced any of the following:</strong></td>
</tr>
<tr>
<td>Frequent trouble sleeping</td>
</tr>
<tr>
<td>Weight gain or loss</td>
</tr>
<tr>
<td>Loss of appetite</td>
</tr>
<tr>
<td>Fever</td>
</tr>
<tr>
<td>Fatigue</td>
</tr>
</tbody>
</table>

### Antecedentes médicos/Revisión por sistemas

| **Ha experimentado alguno de los siguientes síntomas:** |
| Frecuente dificultad para dormir | Sí | No |
| Aumento o pérdida de peso | Sí | No |
| Pérdida de apetito | Sí | No |
| Fiebre | Sí | No |
| Fatiga | Sí | No |

## EYES, EARS, NOSE & THROAT/OJOS, OÍDOS, NARIZ y GARGANTA

### Have you experienced any of the following:

| **Ha experimentado alguno de los siguientes síntomas:** |
| Pérdida o cambio en la visión | Sí | No |
| Pérdida o cambio en la audición | Sí | No |
| Sangrado por la nariz | Sí | No |
| Frecuente congestión nasal | Sí | No |
| Frecuente dolor de garganta | Sí | No |
| Frecuente ronquera | Sí | No |
| Dentadura postiza | Sí | No |

## CARDIOVASCULAR

### Have you experienced any of the following:

| **Ha experimentado alguno de los siguientes síntomas:** |
| Dolor o presión en el pecho | Sí | No |
| Palpitaciones en el corazón | Sí | No |
| Problemas con el corazón | Sí | No |
| Presión arterial alta o baja | Sí | No |

## GASTROINTESTINAL

### Have you experienced any of the following:

| **Ha experimentado alguno de los siguientes síntomas:** |
| Estreñimiento | Sí | No |
| Diarrea | Sí | No |
| Sangre en la materia fecal | Sí | No |
| Frecuente indigestión/ácido estomacal | Sí | No |
| Ictericia o hepatitis | Sí | No |
| Hemorroides o enfermedad rectal | Sí | No |
| Problema estomacal, hepático, intestinal | Sí | No |

## GENITOURINARY/GENITOURINARIO

### Have you experienced any of the following:

| **Ha experimentado alguno de los siguientes síntomas:** |
| Micción frecuente o dolor al orinar | Sí | No |
| Sangre en la orina | Sí | No |
| Flujo o secreción | Sí | No |
| Cambio en el funcionamiento | Sí | No |
### MUSCULOSKELETAL/MUSCULOESQUELÉTICO

<table>
<thead>
<tr>
<th>Have you experienced any of the following:</th>
<th>Yes</th>
<th>No</th>
<th>Ha experimentado alguno de los siguientes síntomas:</th>
<th>Sí</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Swollen or painful joints</td>
<td></td>
<td></td>
<td>Dolor o hinchazón en las articulaciones</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rash</td>
<td></td>
<td></td>
<td>Erupciones en la piel</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leg cramps</td>
<td></td>
<td></td>
<td>Calambres en las piernas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recurrent back pain</td>
<td></td>
<td></td>
<td>Dolor recurrente de espalda</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of muscle strength</td>
<td></td>
<td></td>
<td>Pérdida de fuerza muscular</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Falls (in the last 3 months)</td>
<td></td>
<td></td>
<td>Caídas (en los últimos 3 meses)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### NEUROLOGICAL/NEUROLÓGICO

<table>
<thead>
<tr>
<th>Have you experienced any of the following:</th>
<th>Yes</th>
<th>No</th>
<th>Ha experimentado alguno de los siguientes síntomas:</th>
<th>Sí</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paralysis or weakness</td>
<td></td>
<td></td>
<td>Parálisis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epilepsy</td>
<td></td>
<td></td>
<td>Epilepsia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequent or severe headaches</td>
<td></td>
<td></td>
<td>Dolor frecuente o intenso de cabeza</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nervousness</td>
<td></td>
<td></td>
<td>Nerviosismo</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numbness or tingling</td>
<td></td>
<td></td>
<td>Adormecimiento o cosquilleo</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dizziness or fainting spells</td>
<td></td>
<td></td>
<td>Mareos o episodios de desmayos</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss or change of smell/taste</td>
<td></td>
<td></td>
<td>Pérdida o cambio en el olor/gusto</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of memory or amnesia</td>
<td></td>
<td></td>
<td>Pérdida de la memoria o amnesia</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### PSYCHIATRIC/PSIQUIÁTRICO

<table>
<thead>
<tr>
<th>Do you have a history of:</th>
<th>Yes</th>
<th>No</th>
<th>Tiene usted antecedentes de:</th>
<th>Sí</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td></td>
<td></td>
<td>Depresión</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td></td>
<td></td>
<td>Ansiedad</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### RESPIRATORY/RESPIRATORIO

<table>
<thead>
<tr>
<th>Have you experienced any of the following:</th>
<th>Yes</th>
<th>No</th>
<th>Ha experimentado alguno de los siguientes síntomas:</th>
<th>Sí</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shortness of breath</td>
<td></td>
<td></td>
<td>Falta de aliento</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coughed up blood</td>
<td></td>
<td></td>
<td>Espuerta/Tos con sangre</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have a history of:</td>
<td></td>
<td></td>
<td>Tiene usted antecedentes de:</td>
<td>Sí</td>
<td>No</td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
<td>Asma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bronchitis</td>
<td></td>
<td></td>
<td>Bronquitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emphysema</td>
<td></td>
<td></td>
<td>Enfisema</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td></td>
<td></td>
<td>Tuberculosis</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### FEMALE PATIENTS ONLY

<table>
<thead>
<tr>
<th>Have you experienced any of the following:</th>
<th>Yes</th>
<th>No</th>
<th>Ha experimentado alguno de los siguientes síntomas:</th>
<th>Sí</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in menstrual cycle</td>
<td></td>
<td></td>
<td>Cambios en el ciclo menstrual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe cramping</td>
<td></td>
<td></td>
<td>Dolores Intensos</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaginal discharge</td>
<td></td>
<td></td>
<td>Flujo vaginal</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### PACIENTES MUJERES SOLAMENTE

<table>
<thead>
<tr>
<th>Have you experienced any of the following:</th>
<th>Yes</th>
<th>No</th>
<th>Ha experimentado alguno de los siguientes síntomas:</th>
<th>Sí</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in menstrual cycle</td>
<td></td>
<td></td>
<td>Cambios en el ciclo menstrual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe cramping</td>
<td></td>
<td></td>
<td>Dolores Intensos</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaginal discharge</td>
<td></td>
<td></td>
<td>Flujo vaginal</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### PAIN ASSESSMENT/EVALUACIÓN DEL DOLOR

<table>
<thead>
<tr>
<th>Do you have pain?</th>
<th>Yes</th>
<th>No</th>
<th>¿Tiene algún dolor?</th>
<th>Sí</th>
<th>No</th>
</tr>
</thead>
</table>

If yes, where? Si la respuesta es sí, ¿en qué parte del cuerpo?

Indicate the severity on a scale from 1-10, below:

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Pain/Ningún dolor</td>
<td>Moderate/Dolor moderado</td>
<td>Worst Possible/El peor dolor posible</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Patient Signature: ____________________________  Print: ____________________________  Date: ____________________________
# Medical History Form

**NewYork-Presbyterian Radiation Oncology**

**Medical History Form:** Your answers on this form will help your doctor understand your medical needs. Best estimates are fine if you cannot remember the specific details.

## Past Medical History

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS or HIV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anemia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arthritis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back trouble</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bladder infections</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bleeding tendency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COPD/Emphysema</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastric reflux</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hemorrhoids</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High blood pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liver disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Migraines</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumonia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seizures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td></td>
<td></td>
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<tr>
<td>Thyroid disease</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please list any other medical conditions not listed above:

- **Have you ever:**
  - Been diagnosed with Lupus? [ ] Yes [ ] No
  - Been diagnosed with Scleroderma? [ ] Yes [ ] No
  - Been diagnosed with Ulcerative Colitis? [ ] Yes [ ] No
  - Been diagnosed with Crohn’s disease? [ ] Yes [ ] No
  - Received chemotherapy? [ ] Yes [ ] No
  - Had a pacemaker or defibrillator implanted? [ ] Yes [ ] No
  - If yes, when? __________________________
  - If yes, which company? ___________________
  - Have you ever received radiation therapy? [ ] Yes [ ] No
  - If yes, to which body part and when? __________________________
  - Which hospital? __________________________

## Past Surgical History

Please list any prior surgeries you have had and the approximate date:

<table>
<thead>
<tr>
<th>Surgery</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
</tr>
</tbody>
</table>

## Family History

Have any of your first degree relatives had cancer?

<table>
<thead>
<tr>
<th>Relative</th>
<th>Yes</th>
<th>No</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Siblings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Social History

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Marital Status</th>
<th>Lives with:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Smoking**

- Do you currently smoke? [ ] Yes [ ] No
- Did you smoke in the past? [ ] Yes [ ] No
- If Yes to either: Years smoked: Packs per day:

**Alcohol**

- Do you currently drink alcohol? [ ] Yes [ ] No
- If Yes, drinks per day:

**Other Substances**

- Do you use any other substances? [ ] Yes [ ] No
- Have you in the past? [ ] Yes [ ] No

- If Yes, describe use:

Patient Signature: __________________________

Print: __________________________

Date: __________________________
How else can we use or share your health information?

We are allowed or required to share your information in other ways—usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
- We can share health information about you for certain situations such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medications
  - Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone’s health or safety

Do research
- We can use or share your information for health research.

Comply with the law
- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with the federal privacy law.

Respond to organ and tissue donation requests
- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers’ compensation, law enforcement, and other government requests
- We can use or share health information about you:
  - For workers’ compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
- We can share health information about you in response to a court or administrative order, or in response to a subpoena.
- We do not create or manage a hospital directory.
- In addition to the federal rules regarding health care privacy, we will follow New York State law. For example, we will obtain appropriate written consent from you before we share information concerning genetic information, HIV status, substance abuse treatment, and certain mental health information for purposes other than treating you or obtaining payment for services we provide to you.
- Please ask your physician for information about how to sign up for our patient portal.

Our responsibility

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us you can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, see www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticeapp.html

Changes to the terms of this notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

This notice covers:
- The faculty practices of Columbia University Medical Center known as ColumbiaDoctors
- Columbia’s physicians, dentists, health care, and allied health professionals when practicing on Columbia University-owned or leased space, as well as their clinical support staff

If you receive treatment at another location, for example NewYork-Presbyterian Hospital, the Notice of Privacy Practices you receive at such other location will apply.

Office of HIPAA Compliance
630 West 168th Street, Box 159
New York, NY 10032
Tel. 212.305.7315  Fax. 212.342.5173
E-mail: HIPAA@columbia.edu
http://www.cumc.columbia.edu/hipaa/
Effective Date: August 1, 2014
YOUR RIGHTS

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 10 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
- We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, whom we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights have been violated

- You can complain if you feel we have violated your rights by contacting us using the information on the back page.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.
- Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.
- Example: We use health information about you to manage your treatment and services.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.
- Example: We give information about you to your health insurance plan so it will pay for your services.

continued on next page
NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

DATE:____________________

I acknowledge that I was provided with a copy of the ColumbiaDoctors Notice of Privacy Practices.

Patient Name (Print)  Patient Signature

If completed by a patient’s personal representative, please print and sign your name in the space below

Personal Representative (Print)  Personal Representative’s Signature

Relationship

For ColumbiaDoctors use only

Complete this section if this form is not signed and dated by the patient or patient’s personal representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of ColumbiaDoctors Notice of Privacy Practices but was unable to for the following reason:

☐ Patient refused to sign
☐ Patient unable to sign
☐ Other __________________________

_________________________________  _________________________
Employee Name  Date

This form should be placed in the patient’s medical record

Revised March 2014
How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone’s health or safety

Comply with the law
- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests
- We can share health information about you with organ procurement organizations

Work with a medical examiner or funeral director
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
- We can use or share health information about you:
  - For workers’ compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

In addition we will follow New York State rules regarding health care privacy. We will obtain appropriate authorization before we share information concerning reproductive health, HIV status and certain mental health information.

In order to access your health information at your convenience, we urge you to access our patient portal at myNYP.org. Please ask us for information about how to sign up.

Our Responsibilities
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date: September 23rd, 2013

This Notice of Privacy Practices applies to
NewYork-Presbyterian Hospital
Compliance & Privacy Office

NewYork-Presbyterian

We Put Patients First

We Put Patients First
When it comes to your health information, you have certain privacy rights.
This section explains your rights and some of our responsibilities to help you.

Get a list of those with whom we've shared information
You can ask for a list (accounting) of the times we've shared
your health information for six years prior to the date you ask, who we shared it with, and why.
We will include all the disclosures except for those about
treatment, payment, and health care operations, and certain
other disclosures (such as any you asked us to make). We'll
provide one accounting a year for free but will charge a
reasonable, cost-based fee if you ask for another one
within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even
if you have agreed to receive the notice electronically. We
will provide you with a paper copy promptly.

Choose someone to act for you
If you have given someone medical power of attorney or
if someone is your legal guardian, that person can exercise
your rights and make choices about your health
information.
We will make sure the person has this authority and can act
for you before we take any action.

File a complaint if you feel your rights are violated
You can complain if you feel we have violated your rights
by contacting us using privacy@nyoh.org or
by calling 212-746-1644.
You can file a complaint with the U.S. Department of
Health and Human Services Office for Civil Rights by
sending a letter to 200 Independence Avenue, S.W.,
Washington, D.C. 20201, calling 1-877-696-6775, or by
visiting the following website
www.hhs.gov/ocr/privacy/hipaa/complaints/
We will not retaliate against you for filing a complaint.

For certain health information, you can tell us
your choices about what we share.
If you have a clear preference for how we share your infor-
mation in the situations described below, talk to us. Tell us
what you want us to do, and we will follow your instructions.

In these cases, you have both the right and the choice
to tell us to:
Share information with your family, close friends, or others
involved in your care
Share information in a disaster relief situation
Include your information in a hospital directory
If you are not able to tell us your preference, for example if
you are unconscious, we may go ahead and share your
information if we believe it is in your best interest.
We may also share your information when needed to lessen
a serious and imminent threat to health or safety.

In these cases, we never share your information unless you
give us written permission:
Marketing purposes
Sale of your information
Most sharing of psychotherapy notes

In the case of fundraising:
We may contact you for fundraising efforts, but you can tell
us not to contact you again.

How do we typically use or share
your health information?
We typically use or share your health information in the following ways.

Treat you
We can use your health information and share it with other
professionals who are treating you
Example:
A doctor treating you for an injury asks another doctor
about your overall health condition.

Run our organization
We can use and share your health information to run our
hospital, improve your care, and contact you
when necessary
Example:
We use health information about you to manage your
treatment and services.

Bill for your services
We can use and share your health information to bill and
get payment from health plans or other entities.
Example:
We give information about you to your health insurance
plan so it will pay for your services.

NewYork-Presbyterian
Date: _______ / _______ / ________  Time: ______________ AM/PM

The Notice of Privacy Practices describes how Protected Health Information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

NewYork-Presbyterian Hospital is required by law to protect the privacy of health information that may reveal your identity, and to provide you the health information privacy practices of our Hospital, its medical staff, and affiliated health care providers that jointly perform payment activities and business operations with our Hospital. “Protected Health Information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

_____________________________________
Signature of Patient/Health Care Agent/Guardian/Relative

☐ Patient is unable to sign due to medical reasons
☐ Patient refuses to sign
☐ Other (Please Explain) ____________________________

This Acknowledgement Form will become part of your permanent medical record.
AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION/MEDICAL RECORDS

Patient Name (please print):  
Maiden or Other Name (please print):  
Patient Date of Birth: / / 

Patient Address (please print): 

Telephone (Area Code and Number):  
Email address (please print):  
Medical Record Number:  

Name, address and telephone number of Person(s) or Entity to whom this information will be sent. Please check if same as above:  
Send to (please print): 

New York Presbyterian / Columbia University Medical Center - Department of Radiation Oncology

Address (please print): 
622 W. 168th Street, CHONY North, B-Level, Room 11, New York, NY 10032

Telephone (Area Code and Number):  
Fax (Area Code and Number):  
(212) 305-7077  
(212) 305-5935

Check the name of the Center to disclose information or choose Other Healthcare Provider (specify): 
☐ NYP/Columbia University Medical Center (NYP/Allen Hospital; NYP/Morgan Stanley Children's Hospital)  
☐ NYPWell Cornell Medical Center 
☐ NYP/Westchester Division  
☐ NYP/Lower Manhattan 
☐ Other (Provide Name of Entity)  

(please print)

Specify Information to be released (medical records will not be released unless a date of service(s) is identified on this form): 
Medical Record from (insert date) to (insert date) 
☐ Hospital Admission  
☐ Emergency Department  
☐ Ambulatory Surgery  
☐ Outpatient

Specify reports requested (i.e. Lab tests, Radiology Reports, Operative Reports, Discharge Summary, etc.):

Include (Indicate by Initialing below): Please note that the information will not be released if not initialed. 
☐ Alcohol/Drug Treatment  
☐ Mental Health Treatment (except psychotherapy notes)  
☐ HIV/AIDS Related Information  
☐ Genetic Testing Information

Please consider the environment. When possible, NewYork-Presbyterian will provide the information you requested electronically please check preference:  
☐ CD/DVD  
☐ Electronic Delivery

Patients with an active myNYP.org account can request electronic delivery via secure web patient portal at no cost. Please confirm and initial below: 
☐ I have an active myNYP.org account and understand the medical record(s) I requested will be sent to myNYP.org account;  
☐ If my medical record(s) cannot be delivered to myNYP.org account it will be mailed to the above-stated address on CD/DVD

Patient or Personal Representative Initial 

The purpose(s) for which disclosure is authorized (check where applicable):  
☐ Individual's request Medical Care  
☐ Insurance  
☐ Immunization  
☐ Legal 
☐ Other (specify):  

(please print)

I, or my authorized representative, request that health information regarding my care and treatment at NewYork-Presbyterian Hospital (NYP) be disclosed as described on this form. I understand that:  
☐ I may inspect and/or receive a copy of the information described on this Authorization by completing this form and signing below. 
☐ Providers are permitted to charge reasonable fees to recover costs for inspections and/or copying.  
☐ Treatment and payment will not be conditional on whether you sign this authorization. Signing is voluntary, however if you refuse to sign NYP will not release your records.  
☐ By my specifically authorizing the release of HIV/AIDS related alcohol or drug treatment, or mental health treatment information that the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. 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) 305-7450. These agencies are responsible for protecting my rights.  
☐ Alcohol/drug treatment-related information or confidential HIV/AIDS related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.  
☐ I may revoke this authorization at any time by providing written notice to NYP except to the extent that action has already been taken based on this authorization.  
☐ I understand that this Authorization will expire on: Date / / (provide date if less than 1 year) or 1 year after being signed.

Signature of Patient/personal representative (e.g., legal guardian)  

Date 

If personal representative, print name and relationship to patient

Witness or Notary 

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<td>NewYork-Presbyterian Hospital / Columbia University Medical Center</td>
<td>622 West 168th Street</td>
<td>177 Fort Washington Avenue</td>
<td>(212) 305-3270</td>
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<tr>
<td>Morgan Stanley Children's Hospital of NewYork-Presbyterian Hospital</td>
<td>Medical Correspondence Unit</td>
<td>Milstein Lobby New York, NY 10032</td>
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<td>(CHONY)</td>
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<td>The Allen Hospital (TAH)</td>
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<tr>
<td>NewYork-Presbyterian Hospital / Weill Cornell Medical Center</td>
<td>525 East 68th Street</td>
<td>525 East 68th Street</td>
<td>(212) 746-0530</td>
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<tr>
<td></td>
<td>Medical Correspondence Unit</td>
<td>Room P-04 New York, NY 10065-4879</td>
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<tr>
<td>NewYork-Presbyterian Hospital / Westchester Division</td>
<td>21 Bloomingdale Road</td>
<td>21 Bloomingdale Road</td>
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<td>Hall H, Room 006 White Plains, NY 10605</td>
<td>White Plains, NY 10605</td>
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<tr>
<td>NewYork-Presbyterian Hospital / Lower Manhattan</td>
<td>170 William Street</td>
<td>170 William Street</td>
<td>(212) 312-5121</td>
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<tr>
<td></td>
<td>Medical Correspondence Unit</td>
<td>Room M92 New York, NY 10038</td>
<td>and (212) 312-5122</td>
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<td>New York, NY 10038</td>
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Important Information About Paying for Your Care

Health Plan Networks

NewYork-Presbyterian Hospital is a participating provider in many health plan networks. You can find a list of the plans in which we participate at http://nyp.org/payingforcare. Some health plans use smaller networks for certain products they offer so it is important to check whether we participate in the specific plan you are covered by. Our list will tell you if we do not participate in all of a health plan’s products.

Physician Services

It is also important for you to know that the physician services you receive in the Hospital are not included in the Hospital’s charges. Physicians bill for their services separately and may or may not participate in the same health plans as the Hospital. You should check with the physician arranging your Hospital services to determine which plans that physician participates in.

NewYork-Presbyterian Hospital contracts with a number of physician groups, such as anesthesiologists, radiologists and pathologists, to provide services at the Hospital. Contact information for the physician groups the Hospital has contracted with is available at http://nyp.org/payingforcare. You should contact these groups directly to find out which health plans they participate in.

You should also check with the physician arranging for your Hospital services to determine whether the services of any other physicians will be required for your care. Your physician can provide you with the practice name, mailing address, and telephone number of any physicians whose services may be needed.

Your physician will also be able to tell you whether the services of any physicians contracted by NewYork-Presbyterian Hospital are likely to be needed, such as anesthesiologists, radiologists and pathologists. Contact information for these physicians is available at http://nyp.org/payingforcare. You should contact these groups directly to find out which health plans they participate in.

Hospital Charges

Hospitals are required by law to make available information about their standard charges for the items and services they provide. To obtain information about the Hospital’s charges visit us at http://nyp.org/payingforcare.

If You Do Not Have Health Insurance

If you do not have health insurance, you may be eligible for assistance in paying your Hospital bills. Information about financial assistance is available at http://nyp.org/patients/charity-care.html or you may contact our Financial Assistance Office at (866) 252-0101.