Mount Sinai Health Information Exchange (HIE) and Healthix Consent Form

The Mount Sinai Health Information Exchange ("Mount Sinai HIE") and Healthix share information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called e-health or health information technology ("Health IT"). To learn more about Health IT in New York State, read the brochure, "Better Information Means Better Care." You can ask your health care provider for it, or go to the website www.ehealth4ny.org.

In this Consent Form, you can choose whether to allow the health care providers listed on the Mount Sinai HIE website www.mountsinaiconnect.org ("HIE Participants") to obtain access to your medical records through a computer network operated by the Mount Sinai HIE. This can help collect the medical records you have in different places where you get health care, and make them available electronically to the providers treating you. The list of HIE Participants on the website will be updated regularly.

You may also use this Consent Form to decide whether or not to allow employees, agents or members of the medical staff of The Mount Sinai Hospital and Icahn School of Medicine at Mount Sinai (together, "Mount Sinai") to see and obtain access to your electronic health records through Healthix, which is a Health Information Exchange, or Regional Health Information Organization ("RHIO"), a not-for-profit organization recognized by the State of New York. This can also help collect the medical records you have in different places where you get healthcare, and make them available electronically to the providers treating you. This consent gives your permission for any Mount Sinai program in which you are a patient to access your records from your other healthcare providers authorized to disclose information through Healthix. A complete list of current Healthix Information Sources is available from Healthix and can be obtained at any time by checking the Healthix website at http://healthix.org or by calling Healthix at 877-695-4749. Upon request, your provider will print this list for you from the Healthix website.

YOUR CHOICE TO GIVE OR TO DENY CONSENT MAY NOT BE THE BASIS FOR DENIAL OF HEALTH SERVICES OR HEALTH INSURANCE COVERAGE.

PLEASE CAREFULLY READ THE INFORMATION ON THE ATTACHED FACT SHEET, WHICH IS PART OF THIS CONSENT FORM, BEFORE MAKING YOUR DECISION

Your Consent Choices. You can full out this form now or in the future. You have the following choices:
Please check Box 1 or Box 2.

☐ **1. I GIVE CONSENT to ALL of the HIE Participants listed on the Mount Sinai HIE website to access ALL of my electronic health information through the Mount Sinai HIE and I GIVE CONSENT TO ALL employees, agents and members of the medical staff of Mount Sinai to access ALL of my electronic health information through HEALTHIX in connection with any of the permitted purposes described in the fact sheet, including providing me any health care services, including emergency care.**

☐ **2. I DENY CONSENT to ALL of the HIE Participants listed on the Mount Sinai HIE website to access my electronic health information through the Mount Sinai HIE and I DENY CONSENT TO ALL employees, agents, and members of the medicals staff of Mount Sinai to access ANY of my electronic health information through HEALTHIX for any purpose, *even in a medical emergency*.**

Note: UNLESS YOU CHECK THE "I DENY CONSENT" BOX, New York State law allows health care providers treating you in an emergency to gain access to your medical records, including records that are available through the Mount Sinai HIE and Healthix. IF YOU DON'T MAKE A CHOICE, the records will only be shared in an emergency as allowed by applicable law.

_____ _____
Print Name of Patient Patient Date of Birth

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____ _____
Print name of Legal Representative (if applicable) Relationship of Legal Representative to Patient (if applicable)

Ambulatory Patient Notification Record

I acknowledge that I have been given the following Notices and forms, as required by State and Federal regulations where appropriate:

- New York State Patient's Bill of Rights
- New York State Parent's Bill of Rights
- Patient's Responsibilities
- Notice of Privacy Practices
- Health Information Exchange (HIE) and Healthix Consent Form
- An Important Message From Medicare About Your Rights
- New York State Health Care Proxy Form
- Summary of Policy on Advance Directives
- Patient Information on Pain Management
- Appendix & Glossary

By signing below, I acknowledge that I have been provided a copy of the aforementioned Notices and Appendixes, when applicable, and have therefore been advised about my rights and responsibilities as a patient, any options available to me regarding advance directives, of how health information about me may be used and disclosed by the hospital and the facilities listed at the beginning of this notice, and how I may obtain access to and control this information.

_____
Print Name of Patient or Personal Representative

_____ _____
Signature of Patient or Personal Representative Date

_____
Description of Personal Representative's Authority

_____

I was not able to obtain the patient's acknowledgement of receipt of the foregoing Notices upon registration because:

- o The patient refused to sign, despite good faith efforts;
- o The patient was unaccompanied and not alert or oriented;
- o The patient was unaccompanied and needed emergency care;
- o Other: _____.

Employee signature: _____ Employee Title: _____

Print Name: _____ Date: _____

Mount Sinai Beth Israel

Mount Sinai Brooklyn

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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 Beth Israel and/or Mount Sinai Brooklyn** ("MSBI/MSB") with respect to such services and care unless the contracts between MSBI/MSB 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 MSBI/MSB, to cover the cost of the care and treatment rendered to myself or my dependents in the hospital.

Upon receipt of an MSBI/MSB 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 MSBI/MSB immediately upon learning of such coverage, unless otherwise provided by law.

2. RELEASE OF INFORMATION

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

I authorize MSBI/MSB, 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 MSBI/MSB 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 MSBI/MSB 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 MSBI/MSB are participating providers in many health plan networks, and that a list of the plans that MSBI/MSB participates in can be found at http://www.mountsinaihealth.org/static_files/MSHL/Files/Feb16ContractedPayers%20MSB-MSBI.pdf

I understand that physicians and other providers who render services at MSBI/MSB may be employed by or contracted by MSBI/MSB, or may be independent practitioners who are **not** employed or contracted by MSBI/MSB. I further understand that physicians/providers who provide services at MSBI/MSB may not participate in the same health plans as MSBI/MSB, even if they are employed by or contracted by MSBI/MSB.

I understand that charges for physicians'/providers' "professional services" performed at MSBI/MSB are **not** included in MSBI/MSB's charges, and that physicians/providers may bill for their "professional services" separately from MSBI/MSB, even if they are employed by or contracted by MSBI/MSB.

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 MSBI/MSB to provide services (including anesthesiology, pathology and/or radiology) are reasonably anticipated to be provided to me.

I understand that I can determine the health plans participated in by physicians who are employed by MSBI/MSB by accessing the "find a doctor" toolbar at http://www.mountsinaihealth.org and navigating to physicians' profiles to view their insurance participation information.

I understand that I can obtain contact information for physician groups contracted by MSBI to provide hospital services at MSBI by visiting: http://www.mountsinaihealth.org/about-the-health-system/insurance-info/msbi.
I understand that I can obtain contact information for physician groups contracted by MSB to provide hospital services at MSB by visiting: http://www.mountsinaihealth.org/about-the-health-system/insurance-info/msb.

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

Signature of Patient or Authorized Representative	Date	Time
Print Name of Patient/Authorized Representative	Relationship, if signed by person other than patient	
Signature of Witness	Date	Time
Print Signature of Witness		