Welcome to Cancer Care of Western New York.

Please arrive 15 minutes prior to your appointment time.

At Cancer Care of Western New York, we are dedicated to providing the highest level of professionalism and commitment to quality care. Please let either myself or one of our physicians know if you experience anything that does not exemplify this.

If your insurance company requires a referral, we will attempt to obtain it from your primary care physician. We may require your assistance in this matter, depending upon your physician's office policy. Please be sure to have your insurance card with you when you come in to our office.

To make your visit as efficient as possible, please complete the enclosed forms and bring them with you to your visit. We pride ourselves on getting our patients in quickly, so in the event you receive this information after your appointment, it is not necessary to fill out and return the forms.

We invite you to visit our website, **www.cancercarewny.com**, to view the online services we have available, including a complete video library highlighting our practice, providers, and the conditions we treat. You can request non-urgent follow-up appointments, ask for prescription refills, submit non-urgent questions, and complete a patient satisfaction survey to let us know how we are doing.

If you have any questions or concerns, please feel free to contact us at (716) 844-5500. Welcome to the Cancer Care of Western New York family.

Sincerely,

Angela Foxvog
Practice Administrator
Cancer Care of Western New York

CANCER CARE OF WESTERN NEW YORK
NEW PATIENT SELF ASSESSMENT

Name: _____ **Date of birth:** _____

Address: _____

Phone: Home: _____ **Cell:** _____ **Work:** _____

Social Security: _____ E-mail:_____

Sex assigned at birth: ☐ Female ☐ Male **Gender Identity:** ☐ Female ☐ Male ☐ Non-binary

Race (Optional): ☐ Caucasian ☐ African-American ☐ Hispanic ☐ Native American ☐ Alaskan Native ☐ Asian

Marital Status: ☐ Married ☐ Divorced ☐ Partnered ☐ Single Widowed

Height: _____ **Weight:** _____

Pharmacy: _____

Advance Directives: ☐ Health Care Proxy ☐ Power of Attorney **** Please bring a copy with you.****

Have you every had or are you currently having cancer treatment, including radiation therapy and/or chemotherapy?
☐ Yes ☐ No If yes, please indicate when, where, and type of cancer:

Radiation therapy: _____

Chemotherapy: _____

Hormone therapy: _____

Past Medical History

Inflammatory bowel disease	☐ Yes	☐ No
Crohn's disease	☐ Yes	☐ No
Ulcerative colitis	☐ Yes	☐ No
Autoimmune disease	☐ Yes	☐ No
Rheumatoid arthritis	☐ Yes	☐ No
Lupus	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Implanted defibrillator	☐ Yes	☐ No
Blood thinners	☐ Yes	☐ No

Other medical issues: _____

_____

_____

If you have pain, where is it located: _____

_____

_____

Please Circle the Face which best describes your current level of pain.

Social History

Living arrangement: ☐ Alone ☐ With family ☐ Care facility

Do you have reliable transportation? ☐ Yes ☐ No

Do you smoke tobacco? ☐ Yes ☐ No If yes: How much:_____ How Long:_____

Did you ever smoke tobacco? ☐ Yes ☐ No If yes: How much:_____ How Long:_____ Year Quit:_____

Do you chew tobacco? ☐ Yes ☐ No

Do you vape? ☐ Yes ☐ No If yes: How Long:_____

Do you drink alcohol? ☐ Never ☐ Occasionally ☐ Weekly ☐ Daily Type:_____ How much: _____

Do you use recreational drugs? ☐ Yes ☐ No If yes: Type:_____ How Often:_____

Did you ever use recreational drugs? ☐ Yes ☐ No If yes: Type:_____ How Often:_____

FOR WOMEN ONLY

Menstrual History: Age of onset: _____ Have you reached menopause? ☐ Yes ☐ No

Pregnancies: Is there a chance you may be pregnant now? ☐ Yes ☐ No

Age at first pregnancy:_____

Number of pregnancies:_____ Number of live births:_____

Have you ever been on birth control? ☐ Yes ☐ No If yes, for how long? _____

Current Medication List

Medication/Supplement Prescribed and over the counter	**Dose/Frequency**	**Prescribed by**	**Reason for use**

List medication allergies and reactions: _____

_____

_____

☐ **No known drug allergies**

Family History

Relation	Age	General Health/Illnesses	Cancer History Y/N	If deceased age and cause of death
Father				
Mother				
Siblings				
Other				

Surgeries: Please list all surgeries

Date	Type of Surgery	Where

Are you under the care of any other physicians? ☐ Yes ☐ No

Physician Name	Specialty	Address or Phone Number

CANCER CARE OF WESTERN NEW YORK

Review of Systems

Name:
DOB:
Account:

Please check any of the symptoms that you are experiencing **NOW**:

1. **General**
   - ☐ Weight gain
   - ☐ Weight loss
   - ☐ Appetite increase
   - ☐ Appetite decrease
   - ☐ Fatigue, weakness, or low energy
   - ☐ Fever
   - ☐ None

2. **Eyes, Ears, Nose, Throat, Mouth**
   - ☐ Wears glasses or contact lenses
   - ☐ Visual difficulty (loss of vision, double or blurred vision
   - ☐ Loss of hearing
   - ☐ Ear aches
   - ☐ Chronic sinus problems
   - ☐ Nose bleeds
   - ☐ Lumps in neck/throat
   - ☐ Speech/voice problems
   - ☐ Throat pain
   - ☐ None

3. **Cardiovascular**
   - ☐ Chest pain (angina)
   - ☐ Heart palpitations
   - ☐ Swollen legs or feet
   - ☐ Fluid retention
   - ☐ Varicose veins
   - ☐ None

4. **Skin**
   - ☐ Rash, bumps
   - ☐ Change in skin color
   - ☐ Persistent itch
   - ☐ Infections
   - ☐ None

5. **Gastrointestinal**
   - ☐ Diarrhea
   - ☐ Constipation
   - ☐ Rectal Bleeding
   - ☐ Hemorrhoids
   - ☐ Abdominal pain, cramping
   - ☐ Nausea/vomiting
   - ☐ Heartburn
   - ☐ Difficulty swallowing
   - ☐ None

6. **Respiratory**
   - ☐ Shortness of breath
   - ☐ Cough
   - ☐ Wheezing
   - ☐ Coughing up blood
   - ☐ Chronic bronchitis
   - ☐ None

7. **Genitourinary**
   - ☐ Painful urination
   - ☐ Blood in urine
   - ☐ Frequent urination day or night
   - ☐ Weak stream
   - ☐ Retention of urine
   - ☐ Urgency
   - ☐ Erection problems (male)
   - ☐ None

8. **Endocrine**
   - ☐ Excessive thirst
   - ☐ Excessive urination
   - ☐ Cold intolerance
   - ☐ Heat intolerance
   - ☐ Excessive hunger
   - ☐ Thyroid problem
   - ☐ None

9. **Neurological**
   - ☐ Headaches
   - ☐ Dizziness/fainting
   - ☐ Weakness
   - ☐ Tremors
   - ☐ Paralysis
   - ☐ None

10. **Musculoskeletal**
    - ☐ Muscle/joint aches/pains
    - ☐ Leg pain when walking
    - ☐ Difficulty walking/standing
    - ☐ Back/joint pain
    - ☐ Numbness or tingling
    - ☐ None

11. **Hematologic/Lymphatic**
    - ☐ Anemia
    - ☐ Swollen glands
    - ☐ Easy bruising
    - ☐ Enlarged lymph nodes
    - ☐ Abnormal bleeding
    - ☐ None

2. **Immunologic/Infections**
   - ☐ Severe allergic reactions
   - ☐ Frequent infections
   - ☐ Hay fever
   - ☐ Drug allergies
   - ☐ None

13. **Mental Health**
    - ☐ Anxiety
    - ☐ Depression
    - ☐ Memory loss or confusion
    - ☐ Trouble sleeping/insomnia
    - ☐ None

Patient signature:_____ Date:_____

CANCER CARE OF WESTERN NEW YORK
Office Guidelines

- Provide, to the best of your knowledge, accurate and complete information about your present symptoms, past illnesses, allergies, hospitalizations, medications, and other matters relating to your health.

- **After hours calls:** Our providers will not be able to return your call if you do not accept blocked calls. If you have a medical emergency, call 911 or go to the nearest emergency room.

- After hours answering service cannot refill prescriptions. Please call back during normal office hours to request a refill.

- If you are unable to keep your scheduled appointment, please notify our office as soon as possible. Excessive missed appointments may result in discharge from our practice.

- Please arrive on time for your appointment. Patients who do not arrive within 15 minutes of their scheduled appointment time may be asked to reschedule.

- Follow the treatment plan agreed upon. If you leave the office without scheduling to begin radiation, then it is your responsibility to call our office to schedule follow up discussions.

- Please treat patients and all staff with courtesy and respect. Impolite and disruptive behavior will not be tolerated and may result in discharge from our practice.

POLICY WITH RESPECT TO RECORDING PATIENT APPOINTMENTS

Cancer Care of Western New York does not allow any recording of patients consult or visits with our medical professionals. We understand that there are times where such recordings may be beneficial to you in order to help with remembering a physician's explanation of diagnosis or treatment options and to share with family members in order to help them assist with medications or plan of care. We, as a group, discussed recording of appointments in depth and decided to not allow recordings in our practice, as they are not a legal part of our electronic medical record and do not want to be responsible for partial recordings that may cause confusion with your diagnosis or treatment. As well, we do not allow recording so as to prevent any HIPPA breach if a recording did become lost.

We appreciate your understanding on our policy of NO recording of any appointments.

I, Harlem Ccwny, agree that under no circumstance will I or anyone accompanying me to my appointment will record any office appointment with any of our medical staff.

I agree to the terms of the policy.

Patient will sign electronically at the first office visit. Keep this copy for your records.

CANCER CARE OF WESTERN NEW YORK

MEDICAL HISTORY CONSENT

Patient will sign electronically at the first office visit. Keep this copy for your records.

CONFIRMATION OF MEDICAL HISTORY

I have read the questions on pages 1, 2, and 3 and have completed them truthfully and to the best of my ability.

ASSIGNMENT OF BENEFITS/AUTHORIZATION FOR MEDICARE/INSURANCE BILLING

I request that payment of authorized Medicare and/or other insurance company benefits be made on my behalf for any services furnished me by Cancer Care of WNY, including physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and/or other insurance companies and their agents any information needed to determine these benefits or benefits for related services.

CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND/OR HEALTH CARE OPERATIONS

I hereby consent to the use and disclosure of my Protected Health Information by Cancer Care of WNY for purposes of treatment, payment and/or healthcare operations. I hereby consent to the use and disclosure of my Protected Health Information by Cancer Care of WNY to arrange for treatment by another provider or for the referral of another provider or entity, including a Business Associate of Cancer Care of WNY, and for business operations of Cancer Care of WNY or its related treatment entities.

I understand that my signature on the consent is required in order for me to receive care from the Physician Practice and that the Physician Practice may condition my treatment on obtaining my consent for use and disclosure of my Protected Health Information for its treatment, payment and health care operations.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that further information on the Physician Practice's uses and disclosures of my Protected Health Information is included in the Physician Practice's Notice of Privacy Practices. I acknowledge receipt of Cancer Care of WNY's Notice of Privacy Practices.

CONSENT FOR MEDICAL RECORD PHOTOGRAPHY

I hereby consent to having my photograph taken as part of my medical record. The taking of the photography will assist Cancer Care of WNY, in the identification of patients and will assist in eliminating record misidentification. This photograph will be part of my medical record and shall remain strictly confidential to the same extent as my patient records remain confidential under Cancer Care of WNY's policy and New York State Law.

CANCER CARE OF WESTERN NEW YORK
New York State Department of Health
Medical Records Release

Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related information

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

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in item 8. 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 8, I specifically authorize release of such information to the person(s) indicated in Item 6.

2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose 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/AIDS-related information, I May contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this Information:

_____

6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:
Cancer Care of Western New York, Harlem Professional Park,
3085 Harlem Road, Ste 200, Cheektowaga, NY 14225

7. Purpose for Release of Information: **Medical Records Release**

8. Unless previously revoked by me, the specific information below may be disclosed from: _____ until _____

All health information (written and oral), except: _____

☐ For the following to be included, indicate the specific information to be disclosed and initial below.	Information to be Disclosed	Initials
☐ Records from alcohol/drug treatment programs	_____	_____
☐ Clinical records from mental health programs*	_____	_____
☐ HIV/AIDs-related Information	_____	_____

9. If not the patient, name of person signing form: _____

10. Authority to sign on behalf of patient: _____

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

Patient will sign electronically at the first office visit. Keep this copy for your records.

_____ _____
Signature of Patient or Representative Authorized by Law Date

Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative.

_____ _____ _____
Staff Person's Name & Title Signature Date

This form may be used in place of DOH-2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment-related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure. *** Note:** Information from mental health clinical records may be release pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person. DOH-5032 (4/11)

CANCER CARE OF WESTERN NEW YORK
HEALTH CARE PROXY
About the Health Care Proxy

This is an important legal form. Before signing this form, you should understand the following facts:

1. This form gives the person you choose as your agent the authority to make all health care decisions for you, except to the extent you say otherwise in this form. "Health care" means any treatment, service or procedure to diagnose or treat your physical or mental condition.
2. Unless you say otherwise, your agent will be allowed to make all health care decisions for you, including decisions to remove or provide life-sustaining treatment.
3. Unless your agent knows your wishes about artificial nutrition and hydration (nourishment and water provided by a feeding tube), he or she will not be allowed to refuse or consent to those measures for you.
4. Your agent will start making decisions for you when doctors decide that you are not able to make health care decisions for yourself.

You may write on this form any information about treatment that you do not desire and/or those treatments that you want to make sure you receive. Your agent must follow your instructions (oral and written) when making decisions for you.

If you want to give your agent written instructions, do so right on the form. For example, you could say:

*** If I become terminally ill, I do/don't want to receive the following treatments...**
*** If I am in a coma or unconscious, with no hope of recovery, then I do/don't want...**
*** If I have brain damage or a brain disease that makes me unable to recognize people or speak and there is no hope that my condition will improve, I do/don't want...**
*** I have discussed with my agent my wishes about_____ and I want my agent to make all decisions about these measures.**

Examples of medical treatments about which you may wish to give your agent special instructions are listed below. This is not a complete list of the treatments about which you may leave instructions:

* artificial respiration
* artificial nutrition and hydration (nourishment provided by feeding tube)
* cardiopulmonary resuscitation (CPR)
* antipsychotic medication
* electric shock therapy
* antibiotics
* psychosurgery
* dialysis
* transplantation
* blood transfusions
* abortion
* sterilization

Talk about choosing an agent with your family and/or close friends. You should discuss this form with a doctor or another health care professional, such as a nurse or social worker, before you sign it to make sure that you understand the types of decisions that may be made for you. You may also wish to give your doctor a signed copy. You do not need a lawyer to fill out this form.

You may choose any adult (over 18), including a family member or close friend, to be your agent. If you select a doctor as your agent, he/she may have to choose between acting as your agent or as your attending doctor; a physician cannot do both at the same time. Also, if you are a patient or resident of a hospital, nursing home, or mental hygiene facility, there are special restrictions about naming someone who works for that facility as your agent. You should ask the staff at the facility to explain those restrictions.

You should tell the person you choose that he/she will be your health care agent. You should discuss your health care wishes and this form with your agent. Be sure to give him or her a signed copy. Your agent cannot be sued for health care decisions made in good faith.

Even after you have signed this form, you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped if you object. You can cancel the control given to your agent by telling him/her or your health care provider orally or in writing.

Filling Out the Proxy Form

Item (1) Write your name and the name, home address, and telephone number of the person you select as your agent.
Item (2) If you have special instructions for your agent, you should write them here. Also, if you wish to limit your agent's authority in any way, you should say so here. If you do not state any limitations, your agent will be allowed to make all health care decisions that you could have made, including the decision to consent to or refuse life-sustaining treatment.
Item (3) You may write the name, home address, and telephone number of an alternate agent.
Item (4) This form will remain valid indefinitely unless you set an expiration date or condition for its expiration. This section is optional and should be filled in only if you want the health care proxy to expire.
Item (5) You must date and sign the proxy. If you are unable to sign yourself, you may direct someone else to sign in your presence. Be sure to include your address.

Two witnesses of at least 18 years of age must sign your proxy. The person who is appointed agent or alternate agent cannot sign as a witness.

CANCER CARE OF WESTERN NEW YORK

HEALTH CARE PROXY

DO NOT make any marks above this line

(1) I, _____

hereby appoint _____
(name, home address, and telephone number)

_____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect when and if I become unable to make my own health care decisions.

(2) Optional instructions: I direct my agent to make health care decisions in accord with my wishes and limitations as stated below, or as he/she otherwise knows. (Attach additional pages if necessary.)

_____

_____

_____

_____

(Unless your agent knows your wishes about artificial nutrition and hydration (feeding tubes), your agent will not be allowed to make decisions about artificial nutrition and hydration. (See instructions for filling out the Proxy form.)

(3) Name of substitute or fill-in agent if the person I appoint above is unable, unwilling, or unavailable to act as my health care agent.

_____
(name, home address, and telephone number)

_____

(4) Unless I revoke it, this proxy shall remain in effect indefinitely, or until the date or conditions stated below. This proxy shall expire (specific date or conditions, if desired):

_____

(5) Signature _____

Address _____

Date _____

Statement by Witnesses (must be 18 or older)

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his/her own free will. He/She signed (or asked another to sign for him/her) this document in my presence.

Witness 1 _____

Address _____

Witness 2 _____

Address _____

CANCER CARE OF WESTERN NEW YORK

Patient Bill of Rights

1. The patient has the right to competent medical care delivered without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation, or source of payment.

2. The patient has the right to dignity, respect, courtesy, responsiveness, and timely attention to health care needs.

3. The patient has the right to privacy and confidentiality of information and records regarding their care.

4. The patient has the right to know the names, professional titles, and functions of the physicians, nurses, and other staff members involved in their care.

5. The patient has the right to considerate and respectful care in a clean and safe environment.

6. The patient has the right to be informed of the risks, benefits, and alternatives to proposed care and treatment and to consent to care or treatment. The patient has the right to information about the current diagnosis, treatment, and prognosis. If it is not advisable to give such information to the patient for health reasons, it should be available to a person designated by that patient or a legally authorized person.

7. The patient has the right to refuse any diagnostic procedure or treatment, and to be advised of the likely medical consequences of such refusal.

8. The patient has the right to education to address his or her needs. The education process will consider the patient's values, abilities, readiness to learn, and patient and family responsibilities in the care process.

9. The patient has the right to change the practitioner if other qualified practitioners are available.

10. The patient has the right to request and receive information about alternate sources of appropriate care.

11. The patient has the right to inspect and obtain a copy of his or her medical records. In addition, the patient has the right to expect a reasonable and timely transfer of information from one practitioner to another when requested or required. Charges for copies of medical records shall not exceed the charges provided for by Section 17 of the Public Health Law.

12. The patient has the right to request and receive information concerning the bill for services regardless of the source of payment.

13. The patient has the right to know about the expectations of the office based practice with regard to his or her behavior and the consequence of failure to comply with these expectations, including the right to have reasonable arrangements made for continuation of care as necessary.

14. The patient has the right to help with understanding these rights if they need help.

Patient will sign electronically at the first office visit. Keep this copy for your records.

Authorization to Access and Share Health Care Information Through Carequality Exchange

I understand that Cancer Care of Western New York (CCWNY) participates in the Carequality Query-Based Document Exchange, which is a computer network by which documents containing healthcare information about me may be shared among medical providers and others involved in the provision of my health care. The network includes the exchange of information through a National Record Locator Service (NRLS) provided by SureScripts. I request that health information regarding my care and treatment be accessed and shared as set forth on this form. (More information regarding your choice in relation to the NRLS may be found at www.SureScripts.com.)

The choice I make in this form will NOT affect my ability to get medical care. The choice I make on this form does NOT allow health insurers access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills. This form pertains only to the exchange of information through Carequality; it does not relate in any way to the exchange of information by other means as permitted or restricted by federal and state medical privacy laws.

Details about patient information accessed and shared through Carequality:

1. **How your information may be used:** With limited exceptions, if you give consent, CCWNY may access your electronic health information only for purposes of the following healthcare services. (Other participants with Carequality are responsible for ensuring that they access any information shared by CCWNY only for such purposes and in accordance with applicable laws, and CCWNY assumes no liability in that regard.)

   - **Treatment Services.** Provide you with medical treatment and related services.
   - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
   - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
   - **Quality Improvement Activities**. Evaluate and improve the quality of medical care provided to you and other patients.

2. **What types of information about you may be accessed and shared.** The information accessed and shared by CCWNY may includediagnoses, medications, lab tests, allergies, medical history, trauma history, hospital discharges, employment, living situation, social supports, and health insurance claims history. It may include information regarding alcohol or drug abuse care, mental health care, HIV/AIDS-related care, birth control and abortion, genetic diseases or tests, sexually-transmitted diseases, and other sensitive conditions. CCWNY has implemented certain controls in an effort to prevent the sharing of any information about you through Carequality if you have experienced one or more sensitive conditions. As a result, it is possible that no information about you will be shared by CCWNY in response to an inquiry made by someone else through Carequality, in which case the inquiring party will need to furnish CCWNY with a separate authorization, signed by you, permitting release of your information. It also is possible that because of the confidentiality controls implemented by CCWNY, the inquiring party may not know that you have received treatment by CCWNY unless you have notified that party. You understand that CCWNY's implementation of these controls is an effort to balance protection of your sensitive information with the sharing of information about you. CCWNY assumes no liability in the event the implementation of these controls results in non-disclosure of information to another treatment provider.

3. **Where health information about you comes from:** Information about you comes from places where you have received medical care or health insurance. These may include hospitals, physician offices, pharmacies, clinical laboratories, health insurers, the Medicare and Medicaid programs, and other organizations that exchange health information electronically.

4. **Who may access information about you, if you give consent:** Only those who carry out activities permitted by this form as described above in paragraph one. Your information may also be accessed without your consent by Public Health Agencies if permitted by State and/or Federal Law. Any data received from a 42 C.F.R. Part 2 designated facility (certain providers of alcohol or drug abuse care) may be essed only where there is a treating provider relationship.

5. **Re-disclosure of information:** Any Carequality participant to whom you have given consent to access health information about you may re-disclose your health information to the extent permitted by state and federal laws and regulations.

6. **Effective period:** This Consent Form will remain in effect until the day you change your consent choice.

7. **Changing your consent choice:** You can change your consent choice at any time by submitting a new form indicating your new choice. If CCWNY accesses your health information through Carequality while your consent is in effect, CCWNY may copy or include your information in CCWNY's own records. CCWNY is not required to return your information or remove it from CCWNY's records if you later decide to change your consent decision.

My Consent Choice (please check ONE box below to indicate your choice). I can change my decision at any time by completing a new form.

☐ **1. YES** **I GIVE CONSENT to Cancer Care of Western New York to access and share my health information through the Carequality Exchange.**

☐ **2. NO** **I DENY CONSENT for Cancer Care of Western New York to share and access my health information through the Carequality Exchange for any purpose, even in a medical emergency. (I understand that checking this box prohibits the exchange of information through the Carequality Exchange, even in the event of a medical emergency, in which case the information would need to be requested and shared by other means.)**

Print Name of Patient's Legal Representative (if applicable)

Relationship of Legal Representative to Patient (if applicable)
☐ **Parent** ☐ **Healthcare agent/proxy** ☐ **Guardian** ☐ **Other:**

I understand that upon my request Carequality is required to provide me with a list of disclosures of my electronic health information.

This form has been explained to me, and any questions I had about it have been answered to my satisfaction. I understand and agree with the contents of the form. I have been provided with a copy of this form if I requested it.

Patient will sign electronically at the first office visit. Keep this copy for your records.

HEALTHeLINK

Authorization for access to Patient Information Through HEALTHeLINK

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow Participating HEALTHeLINK Providers and Payers (" Participants") who are involved in my care to obtain access to my medical records through the health information exchange organization called HEALTHeLINK. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. HEALTHeLINK is a not-for-profit organization that shares information about people' s health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit HEALTHeLINK' s website at **www.wnyhealthelink.com.**

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. I can change my decision at any time by completing a new form.

___ **1. YES** **I GIVE CONSENT** to all current and future Participants, who are involved in my care, to access ALL of my electronic health information through HEALTHeLINK.

___ **2. YES, EXCEPT SPECIFIC PARTICIPANT(S)** **I GIVE CONSENT** to all current and future Participants, who are involved in my care, to access ALL of my electronic health information through HEALTHeLINK, **EXCEPT** the Participant(s) listed below.

Participant's Name (Provider Office): _____ Participant's address or phone number: _____

___**3. YES, ONLY** **I GIVE CONSENT ONLY** to the specific Participant(s) listed below to access ALL of **SPECIFIC** my electronic health information through HEALTHeLINK **PARTICIPANT(S)**

Participant's Name (Provider Office): _____ Participant's address or phone number: _____

___**4. NO, EXCEPT IN A MEDICAL EMERGENCY** **I DENY CONSENT EXCEPT IN AN EMERGENCY** for current and future Participants to access my electronic health information through HEALTHeLINK.

___ **5. NO, EVEN IN AN EMERGENCY** **I DENY CONSENT** for current and future Participants to access my electronic health information through HEALTHeLINK for any purpose, **even** in a medical emergency.

I understand that my information may be accessed in the event of an emergency, unless I complete this form and check box #5, which states that I deny consent even in a medical emergency.

I understand that upon my request, HEALTHeLINK is required to provide me with a list of disclosures of my electronic health information under the terms of this form.

My questions about this form have been answered and I have been provided a copy of this form if I request it.

Patient will sign electronically at the first office visit. Keep this copy for your records.

Print Name of Patient's Legal Representative (if applicable)

Relationship of Legal Representative to Patient (if applicable)

☐ Parent ☐ Healthcare agent/proxy ☐ Guardian ☐ Other:

Details about patient information in HEALTHeLINK and the consent process:

1. **How Your Information May Be Used**. With limited exceptions, if you give consent, the Participant(s) you approve may use your electronic health information **only** for the following healthcare services:
   - **Treatment Services.** Provide you with medical treatment and related services.
   - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
   - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
   - **Quality Improvement Activities**. Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information About You Are Included**. If you give consent, the Participants you approve may access ALL of your electronic health information available through HEALTHeLINK. This includes information created before and after the date of this Consent Form. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:
   - Alcohol or drug use problems
   - HIV/AIDS
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - Mental health conditions
   - Sexually transmitted diseases

   If you have received alcohol or drug abuse care, your record may include information related to your alcohol or drug abuse diagnoses, medications and dosages, lab tests, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social supports, and health insurance claims history.

3. **Where Health Information About You Comes From.** Information about you comes from places that have provided you with medical care or health insurance ("Information Sources"). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other eHealth organizations that exchange health information electronically. A complete list of current Information Sources is available from HEALTHeLINK at http://wnyhealthelink.com or by calling 716-206-0993 ext. 103.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Participant(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one. Your information may also be accessed without your consent by Public Health Agencies if permitted by State and/or Federal Law. Any data received from a 42 C.F.R. Part 2 designated facility (certain providers of alcohol or drug abuse care) may only be accessed where there is a treating provider relationship. A complete list of Participants is available from HEALTHeLINK at http://wnyhealthelink.com/physicians-staff/current-participants/participating-healthelink-providers/ or by calling 716-206-0993 ext. 103 if you want a hard copy which will be provided at no charge within five (5) business days of the request.

5. **Penalties for Improper Access to or Use of Your Information**. There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call one of the Participants you have approved to access our records; or visit HEALTHeLINK's website at http://wnyhealthelink.com; or call HEALTHeLINK at 716-206-0993 ext. 103; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: http://www.hhs.gov/ocr/privacy/hipaa/complaints/.

6. **Re-disclosure of Information**. Any Participant(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

7. **Effective Period.** This Consent Form will remain in effect until the day you change your consent choice or until such time as HEALTHeLINK ceases operation ***(or until 50 years after your death whichever occurs first)***. If HEALTHeLINK merges with another Qualified Entity our consent choices will remain effective with the newly merged entity.

8. **Changing Your Consent Choice**. You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice(s). Participant(s) that access your health information through HEALTHeLINK while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

GLP – Western New York Urology Associates/Cancer Care of Western New York/Pediatric Urology of Western New York
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Updated: 4/29/22

GLP d/b/a WESTERN NEW YORK UROLOGY ASSOCIATES/CANCER CARE OF WESTERN NEW YORK/PEDIATRIC UROLOGY OF WESTERN NEW YORK uses your Protected Health or Private[1] Information (collectively referred to as "Protected Health Information") for your treatment, to obtain payment for our services and for our operational purposes, such as improving the quality of care we provide to you. We are committed to maintaining your confidentiality and protecting your health information. We are required by law to provide you with this Notice which describes our health information privacy practices. This Notice applies to all information and records related to your care that our physicians, other health care professionals, workforce members and Business Associates (described below) have received or created. It informs you about the possible uses and disclosures of your Protected Health Information and describes your rights and our obligations regarding your Protected Health Information.

We are required by law to:

- maintain the privacy of your Protected Health information;
- provide to you this detailed Notice of our legal duties and privacy practices relating to your Protected Health Information; and
- abide by the terms of the Notice that are currently in effect. We reserve the right to change the terms of this Notice and will notify you or your personal representative if we make any material changes to the Notice.

I. WITH YOUR CONSENT WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

You will be asked to sign a Consent allowing us to use and disclose your Protected Health Information to others to provide you with treatment, obtain payment for our services, and run our health care operations. We will initially limit the use and disclosure or request of your Protected Health Information, to the extent practicable, to a limited data set (a limited data set does not include your direct identifiers) or, if needed, to the minimum necessary to accomplish the intended purpose of such use, disclosure, or request. Here are examples of how we may use and disclose your health information.

For Treatment. Our staff and health care professionals may review and record information in your record about your treatment and care. We will use and disclose this health information to health care professionals in order to treat and care for you. For example, your physician may consult with another physician located at another location to determine how to best treat you.

For Payment. Your physician may use and disclose your Protected Health Information to others in order for us to bill for your health care services and receive payment. For example, we may include your health information in our claim to your insurance company, Medicare, or Medicaid in order to receive payment for services provided to you. We may also disclose your health information to other health care providers so that they can receive payment for their services.

For Health Care Operations. We may use and disclose your Protected Health Information to others for our business operations. For example, we may use Protected Health Information to evaluate our services, including the performance of our staff, and to educate our staff.

Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care.

II. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR OTHER SPECIFIC PURPOSES

Business Associates. We may share your Protected Health Information with our vendors and agents who create, receive, maintain, or transmit PHI for certain functions or activities on behalf of the physician. These are called our "Business Associates" and include any subcontractor that creates, receives, maintains, or transmits PHI on behalf of the physician. For example, we may give your health information to a billing company to assist us with our billing for services, or to a law firm or an accounting firm that assists us in complying with the law and or improving our services. To protect and safeguard your health information we require our Business Associates and subcontractors to appropriately safeguard your information.

Family and Friends Involved in Your Care. Unless you object, we may disclose your Protected Health Information to a family member or close personal friend, including clergy, who is involved in your care or payment for that care.

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[1] Private Information refers to unencrypted personal information in combination with any one or more of the following data elements: 1) social security number, 2) Driver's license or non-driver identification card number, or 3) account number, credit, or debit card number, in combination with any required security or access code which would permit access to an individual's financial account.

Personal Representative. If you have a personal representative, such as a legal guardian, we will treat that person as if that person is you with respect to disclosures of your health information. If you become deceased, we may disclosure health information to an executor or administrator of your estate to the extent that person is acting as your personal representative or to your next of kin, as permitted under state and federal law.

Disaster Relief. We may disclose your Protected Health Information to an organization assisting in a disaster relief effort.

Public Health Activities. We may disclose your Protected Health Information for public health activities including the reporting of disease, injury, vital events, and the conduct of public health surveillance, investigation and/or intervention. We may also disclose your information to notify a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition if a law permits us to do so.

Health Oversight Activities. We may disclose your Protected Health Information to health oversight agencies authorized by law to conduct audits, investigations, inspections and licensure actions or other legal proceedings. These agencies provide oversight for the Medicare and Medicaid programs, among others.

Reporting Victims of Abuse, Neglect or Domestic Violence. If we have reason to believe that you have been a victim of abuse, neglect or domestic violence, we may use and disclose your Protected Health Information to notify a government authority if required or authorized by law, or if you agree to the report.

Law Enforcement. We may disclose your Protected Health information for certain law enforcement purposes or other specialized governmental functions.

Judicial and Administrative Proceedings. We may disclose your Protected Health Information in the course of certain judicial or administrative proceedings.

Research. In general, we will request that you sign a written authorization before using your Protected Health Information or disclosing it to others for research purposes. However, we may use or disclose your health information without your written authorization for research purposes provided that the research has been reviewed and approved by a special Privacy Board or Institutional Review Board.

De-identified Information. We may use your health information to create "de-identified" information, or we may disclose your information to a business associate so that the business associate can create de-identified information on our behalf. When we "de-identify" health information, we remove information that identifies you as the source of the information. Health information is considered "de-identified" only if there is no reasonable basis to believe that the health information could be used to identify you.

Limited Data Set. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research, public health, and health care operations.

Coroners, Medical Examiners, Funeral Directors, Organ Procurement Organizations. We may release your health information to a coroner, medical examiner, funeral director or, if you are an organ donor, to an organization involved in the donation of organs and tissue.

To Avert a Serious Threat to Health or Safety. We may use and disclose your Protected Health Information when necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person. However, any disclosure would be made only to someone able to help prevent the threat.

Military and Veterans. If you are a member of the armed forces, we may use and disclose your Protected Health Information as required by military command authorities. We may also use and disclose Protected Health Information about foreign military personnel as required by the appropriate foreign military authority.

Workers' Compensation. We may use or disclose your Protected Health Information to comply with laws relating to workers' compensation or similar programs.

National Security and Intelligence Activities; Protective Services. We may disclose health information to authorized federal officials who are conducting national security and intelligence activities or as needed to provide protection to the President of the United States, or other important officials.
As Required By Law. We will disclose your Protected Health Information when required by law to do so.

Treatment Alternatives and Health-Related.
We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

III. YOUR AUTHORIZATION IS REQUIRED FOR OTHER USES OF YOUR PROTECTED HEALTH INFORMATION

We will use and disclose your Protected Health Information other than as described in this Notice or required by law only with your written Authorization. You may revoke your Authorization to use or disclose Protected Health Information in writing, at any time. To revoke your Authorization, contact the Medical Records staff. If you revoke your Authorization, we will no longer use or disclose your Protected Health Information for the purposes covered by the Authorization, except where we have already relied on the Authorization.

Fundraising. We may contact you or your personal representative to raise money. We may also share your demographic information with a charitable foundation that may contact you or your personal representative to raise money on our behalf. In certain circumstances, you must provide us with your written authorization for our use of your information for fundraising and you also have the opportunity to opt out or restrict your receiving future fundraising communications. Your request to opt out of receiving future fundraising communication will revoke any prior authorizations and you will not receive any future communications.

Marketing. In most circumstances, we are required by law to receive your written authorization before we use or disclose your health information for marketing purposes. Under no circumstances will we sell our client lists or your health information to a third party without your written authorization.

Psychotherapy Notes. In most circumstances, Physician is required by law to obtain your written authorization before we use or disclose psychotherapy notes.

IV. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights with respect to your health information. If you wish to exercise any of these rights, you should make your request to our Medical Records Supervisor.

Right of Access to Protected Health Information. You have the right to request, either orally or in writing, to inspect and obtain a copy of your Protected Health Information, subject to some limited exceptions. If available, you have the right to access your information in electronic format. If you request copies of the records, we must provide you with copies within a reasonable time but not more than 30 days if the records are maintained onsite or 60 days if the records are maintained off-site. We may charge a reasonable fee for our costs in copying and mailing your requested information or providing information in electronic format.

In certain limited circumstances, we may deny your request to inspect or receive copies. If we deny access to your Protected Health Information, we will provide you with a summary of the information, and you have a right to request review of the denial. We will provide you with information on how to request a review of our denial and how to file a complaint with us or the Secretary of the Department of Health and Human Services.

Right to Request Restrictions. You have the right to request restrictions on the way we use and disclose your Protected Health Information for our treatment, payment, or health care operations. You also have the right to request restrictions on the way we disclose your Protected Health Information to a family member, friend or other person who is involved in your care or the payment for your care.

We are not required to agree to your requested restriction, and in some cases, the law may not permit us to accept your restriction. However, if we do agree to accept your restriction, we will comply with your restriction except in the case of an emergency or if the use or disclosure is required by law. If your restriction applies to disclosure of information to a health plan for payment or health care operations purposes and is not otherwise required by law and where you paid out of pocket, in full, for items or services, we are required to honor that request.

Right to Receive Notice of a Breach. We will notify you by first class mail or by e-mail (if you have indicated a preference to receive information by e-mail), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. A "Breach" means the unauthorized access, acquisition, use, or disclosure of Protected Health Information which compromises the security or privacy of Protected Health Information, except where: (1) an unauthorized person to whom such information is disclosed would not reasonably have been able to retain such information; (2) any unintentional acquisition, access, or use of PHI by an employee or individual acting under the authority of a covered entity or business associate (a) was made in good faith and within the course and scope of the employment or other professional relationship of such employee, or individual, respectively, with the covered entity or business associate; and (b) such information is not further acquired, accessed, or used or disclosed by any person; or (3) any inadvertent disclosure from an individual who is otherwise authorized to access PHI at an agency operated by a covered entity or business associate to another similarly situated individual at the same agency provided that any such information received as a result of such disclosure is not further acquired, accessed, used, or disclosed without authorization. The Physician must notify you of any breach unless we can demonstrate, based on a risk assessment, that there is a low probability that the PHI has been compromised.

Any acquisition, access, use or disclosure of PHI in a manner not permitted by the above paragraph is presumed to be a "Breach" unless Covered Entity or Business Associate, as applicable, demonstrates that there is a low probability that the PHI has been compromised based on a risk assessment of at least the following factors: (i) the nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification; (ii) the unauthorized person who used the PHI or to whom the disclosure was made; (iii) whether the PHI was actually acquired or viewed; and (iv) the extent to which the risk to the PHI has been mitigated.

"Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable and undecipherable to unauthorized users. The notice is required to include the following information:

- a brief description of the breach, including the date of the breach and the date of its discovery, if known;
- a description of the type of Unsecured Protected Health Information involved in the breach;
- steps you should take to protect yourself from potential harm resulting from the breach;
- a brief description of action we are taking to investigate the breach, mitigate losses, and protect against further breaches; and
- contact information, including a toll-free number, e-mail address, Website, or postal address to permit you to ask questions or obtain additional information.

In the event the breach involves 10 or more individuals whose contact information is out of date, we will post a notice of the breach on the home page of our web site or in a major print or broadcast media. If the breach involves more than 500 individuals in the state or jurisdiction, we will send notices to prominent media outlets. If the breach involves more than 500 individuals, we are required to immediately notify the Secretary of Health and Human Services. We are also required to submit an annual report to the Secretary of a breach that involved less than 500 individuals during the year and will maintain a written log of breaches involving less than 500 individuals. Notification to the Secretary will occur within 60 days of the end of the calendar year in which the breach was discovered.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of our disclosures of your Protected Health Information. This is a listing of certain disclosures of your Protected Health Information made by the Provider or by others on our behalf, but does not include disclosures made for treatment, payment and health care operations or certain other purposes unless the records are maintained in an Electronic Health Record. Records maintained in an Electronic Health Record will include disclosures made for treatment, payment, health care operations and other purposes.

You must submit a request in writing, stating a time period that is within six years from the date of your request. Where an Electronic Health Record is used, we will provide you with an accounting of disclosures for a three-year period. You are entitled to one free accounting within one 12-month period. For additional requests, we may charge you our costs.

We will usually respond to your request within 60 days. Occasionally, we may need additional time to prepare the accounting. If so, we will notify you of our delay, the reason for the delay, and the date when you can expect the accounting.

Right to Request Amendment. If you think that your Protected Health Information is not accurate or complete, you have the right to request that we amend such information for as long as the information is kept in our records. Your request must be in writing and state the reason for the requested amendment. We will usually respond within 60 days but will notify you within 60 days if we need additional time to respond, the reason for the delay and when you can expect our response. We may deny your request for amendment, and if we do so, we will give you a written denial including the reasons for the denial and an explanation of your right to submit a written statement disagreeing with the denial.

Right to a Paper Copy of This Notice. You have the right to obtain a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time. You may obtain a copy of this Notice at our website, www.wnyurology.com.

Right to Request Confidential Communications. You have the right to request that we communicate with you concerning personal health matters in a certain manner or at a certain location. For example, you can request that we speak to you only at a private location such as your home, rather than at work. We will accommodate your reasonable requests.

V. COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint in writing with us or with the Office of Civil Rights in the U.S. Department of Health and Human Services. To file a complaint with us, contact our Privacy Officer at 716-844-5000. No one will retaliate or take action against you for filing a complaint.

VI. CHANGES TO THIS NOTICE

We will promptly revise and make this Notice available upon request whenever there is a material change to the uses or disclosures, your individual rights, our legal duties, or other privacy practices stated in this Notice. We reserve the right to change this Notice and to make the revised or new Notice provisions effective for all Protected Health Information already received and maintained by the Provider as well as for all Protected Health Information we receive in the future. We will post a copy of the current Notice in our office and have copies of the Notice available for you at the office.

VII. FOR FURTHER INFORMATION

If you have any questions about this Notice or would like further information concerning your privacy rights, please contact our Privacy Officer at 716-844-5000.