Catholic Health

# Diabetes Class Registration Packet

## Thanks for your interest in our classes!

Please read and follow these instructions:

- **Class Registration Form** – This form registers you for the class of your choice. Fill out completely and submit to us by email, mail, or fax.
- **Hospital Consent and Financial Agreement** – This form allows Catholic Health to bill your insurance. Please sign and date this form, and submit it to us along with your Class Registration form.
- **Acknowledgement of Receipt of Privacy Notice** – You are receiving the Privacy Notice in this packet. Please sign and date form, and submit it to us along with your Class Registration form.
- **Participant Self-Assessment Form** – Fill out completely and submit to us by email, mail, or fax.
- **Preparing for your Telehealth Class** – Instruction for preparing for telehealth class.
- **Patients' Bill of Rights** – Please keep for your records.
- **Privacy Notice** – This notice outlines your privacy rights and responsibilities. Please keep for your records. It is also available on our website.

Catholic Health

# Diabetes Education Classes Registration Form

1. Please complete the form below and circle the class offering that you would like to attend
2. Send your form by any of the methods below, email preferred. Forms must be received *before first* class :
   - Email: HealthConnection@chsbuffalo.org
   - Fax: (716) 706-2545
   - Catholic Health's HealthConnection ◆ 144 Genesee Street, 5th floor, Buffalo, NY 14203
3. If you need payment assistance, please call (716) 601-3600
4. Confirmation of class registration will be emailed to you at the address you provide

**ALL REGISTRANTS: Please fill out this section.**

Last Name: _____ First Name: _____ Date of Birth: _____ Last 4 digits of SS#:_____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____ Gender: M ◯ F ◯ Race_____

Employer: _____ Emergency Name and Phone: _____

Will someone be accompanying you? ☐ Yes ☐ No

**PHYSICIAN INFORMATION: All registrants please fill out this section.**

Primary Physician: _____ Phone: _____

Office Location: _____

Endocrinologist: _____ Phone: _____

Office Location: _____

**INSURANCE INFORMATION: All registrants please fill out this section.**

☐ No Insurance/Self-Pay

Primary Insurance: _____ Policy Number: _____

Subscriber: _____ Group: _____ Plan: _____

Subscribers Employer: _____ Subscriber's Date of Birth: _____

Secondary Insurance: _____ Policy Number: _____

Subscriber's relationship to patient: _____ Medicare Number: _____ Medicaid Number: _____

**CHOOSE YOUR CLASSES:**

**Check the class you would like to attend:**

| | **2021 Diabetes Education WebEx Classes: Each class is a series and you must attend all dates.** | | | | | | |
|---|---|---|---|---|---|---|---|
| ◯ | January, 18,19,20 | WebEx | 9:00am-11:30am | ◯ | June 21,22,23 | WebEx | 9:00am-11:30am |
| ◯ | February 15,16,17 | WebEx | 9:00am-11:30am | ◯ | July 19,20,21 | WebEx | 9:00am-11:30am |
| ◯ | March 8,9,10 | WebEx | 6:00pm-8:30pm | ◯ | August 23,24,25 | WebEx | 9:00am-11:30am |
| ◯ | April 19,20,21 | WebEx | 9:00am-11:30am | ◯ | September 13,14,15 | WebEx | 6:00pm-8:30pm |
| ◯ | May 10,11,12 | WebEx | 6:00pm-8:30pm | ◯ | October 18,19,20 | WebEx | 9:00am-11:30am |
| | | | | ◯ | November 8,9,10 | WebEx | 6:00pm-8:30pm |

**ARTC**
**Administrative Regional Training Center**
**144 Genesee St**
**Buffalo, NY 14203**

**KMH**
**Kenmore Mercy Hospital**
**2950 Elmwood Ave**
**Kenmore, NY 14217**

**MSMH**
**Mount St. Mary's Hospital**
**5300 Military Rd**
**Lewiston, NY 14092**

**SOCH**
**Sisters of Charity Hospital**
**2157 Main St**
**Buffalo, NY 14214**

**SJC**
**St. Joseph Campus**
**2605 Harlem Rd**
**Cheektowaga, NY 14225**

**MHB**
**Mercy Hospital of Buffalo**
**565 Abbott Rd**
**Buffalo, NY 14220**

Kenmore Mercy Hospital,
Mercy Hospital of Buffalo,
Sisters of Charity Hospital- Main Street and St. Joseph Campus

APPENDIX A

Catholic Health System

# HOSPITAL CONSENT AND FINANCIAL AGREEMENT

Patient Identification Information

**AUTHORIZATION FOR PATIENT CARE:** The undersigned patient and/or representative ("Undersigned") hereby grants permission to the employees of Catholic Health System (CHS) facilities/services to render routine patient care, and to carry out the orders of the patient's attending physician, consultants, associates, and assistants of the Undersigned's choice. For the purpose of advancing medical knowledge, the Undersigned understands that the facilities of CHS provide a teaching environment to medical, allied health, and religious students and consents to such students' participating in the patient's care.

**ASSIGNMENTS OF BENEFITS:** The Undersigned hereby certifies that all insurance information reported to all facilities of CHS and all clinical providers for this episode of care include all available sources of coverage, and assigns to the facilities of CHS, sufficient monies from said insurance to pay for the patient's care and treatment. The Undersigned further understands that regardless of assignment of these benefits, the Undersigned is personally responsible for the total charges for services rendered, and further agrees that all amounts are due and payable upon demand. The Undersigned further agrees that the facilities of CHS retain the right to transfer monies from any credit balance account in the Undersigned's name to any other accounts which may be due and payable by the Undersigned

**FOR PATIENTS ENTITLED TO MEDICARE AND/OR MEDICAID BENEFITS:** If applicable, I hereby irrevocably assign payment of all CHS services and medical benefits applicable and otherwise payable to me to the designated CHS facilities and to all clinical providers providing care to me. I certify that the information provided in applying for payment under Title XVIII or XIX of the Social Security Act, is correct and request that payment of authorized benefits are made to the designated CHS facility and all clinical providers providing care on my behalf. The Undersigned authorizes any holder of medical or other information about the patient to release to the Social Security Administration and Centers for Medicare and/or Medicaid Services (CMS) or its intermediaries or carriers, any information needed for this or a related Medicare or Medicaid claim. The Undersigned assigns the benefits payable for physician services to the physician or organization furnishing the services or authorizes such physician or organization to submit a claim to Medicare or Medicaid for payment.

**FINANCIAL AGREEMENT:** In consideration of the services to be rendered to the patient on this date and all future dates, the Undersigned personally guarantees to pay the account of the designated CHS facility/service in accordance with the rates and terms established for the services rendered. The Undersigned also agrees that the CHS facilities and all clinical providers who have provided care or interpreted my tests, along with any billing service and their collection agency or attorney who may work on their behalf, to contact me on my cell phone and/or home phone using pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology or by electronic mail, text messaging or by any other form of electronic communication. The undersigned has been informed that many of the physicians at the CHS facility are privately practicing independent physicians, NOT CHS employees. These physicians (such as x-ray, emergency room, cardiology, etc.) bill separately from CHS for their professional services. The undersigned also agrees that if the account remains delinquent and thereby requires the services of a collection agency and/or lawful authorities for collection, the Undersigned shall pay reasonable attorney's fees and collection expenses. The undersigned has been made aware that the CHS Healthcare Assistance Program allows persons to receive medically necessary services at no charge or reduced charge, if they are eligible, at CHS facilities. Please call (716) 601-3600 to arrange for a payment plan.

**PERSONAL VALUABLES:** I understand and agree that money, jewelry, and other valuables should not be brought into CHS facilities. However, if out of necessity, valuables are brought into the hospital they should be deposited in the hospital safe by Security until the time of my discharge. Items brought into a CHS Long Term Care facility will be catalogued on the Resident Belonging sheet, appropriately labeled and any money deposited in the facility safe during my stay. Residents in long term care will also be provided a locked drawer upon request for personal belongings. I further understand and agree that the CHS facilities shall not be liable for the loss or damage to any personal property kept with me at CHS facilities during my stay. With respect to Home Care, I further understand and agree that CHS Home Care shall not be liable for the loss of or damage to any personal effects kept in my home unless there is proof of willful misconduct by a CHS associate.

I hereby consent to the above and acknowledge that a copy of the "Patient Bill of Rights"/Health Care Proxy Information Packet was made available to me.

Signature:_____ Date:_____ Time:_____

CERTIFICATION: The Undersigned certifies that the Undersigned has read this form, and is either the patient, or has legal authority on behalf of the patient to execute the above and accept its terms; and that all information provided is accurate and complete to the best of the Undersigned's knowledge.

Patient Signature:_____ Date:_____ Time:_____

Representative Name (please print):_____

Representative's Signature:_____ Date:_____ Time:_____

Relationship of Representative to Patient:_____

The Signing of this Form Above, Witnessed by:_____ Date:_____ Time:_____

COMPLETE PAGE TWO –HIPAA CONSENT

*FS0019*

Catholic Health System

Kenmore Mercy Hospital
Mercy Hospital of Buffalo
Sisters of Charity Hospital- Main Street and St. Joseph Campus

Patient Identification Information

# HIPAA Consent and Acknowledgment of Notice of Privacy Practice

**RELEASE OF INFORMATION:** The Undersigned hereby permits the CHS's facilities and agencies, the workforce of such entities, and the members of the CHS's various medical staffs, to disclose the patient's personally identifiable information for purposes related to the patient's treatment, to obtain payment for the patient's treatment, and in the other circumstances listed in the CHS's Privacy Notice where federal law does not require my further Authorization. I hereby authorize and consent to release of all PHI; medical and personal information (including but not limited to my home phone, cell phone, work phone, address and email address) to the CHS facility and to any and all clinical providers responsible for my care: interpretation of test results; account billing and collection; payment posting and/or processing; or related healthcare functions. The Undersigned also grants permission to release medical information to other health care providers involved in the patient's care and to others involved in planning for the care of the patient. The Undersigned likewise grants permission for these parties to release appropriate medical information back to CHS.

**USE OF INFORMATION WITHIN THE CATHOLIC HEALTH SYSTEM:** I understand CHS is composed of numerous facilities and agencies including hospitals, nursing homes, adult care homes, home health care companies and related medical services. I further understand that in order for CHS to effectively operate and to render appropriate health care, it may be necessary to use and review the patient's medical records and information retained at one or more of the facilities of CHS. I therefore authorize the use of the patient's medical information by appropriate personnel and medical staff members within CHS for purposes related to the patient's treatment, to obtain payment for the patient's treatment, and for the healthcare operations of CHS. Additionally, I understand that CHS will include the patient's name, location, general condition and religious affiliation in its Patient Directories, such as a patient census and clergy report. I understand that CHS may disclose Directory Information to members of the clergy and to individuals who ask for the patient by name (except for religious affiliation). I do not object to the use of this limited information about myself in facility Directories.

**PATIENT ACKNOWLEDGEMENT FOR COMMUNICATION VIA THE PORTAL CONSENT.** The Patient Portal will help you communicate with doctors, nurses and other support staff, allow you to see portions of your health information and in the future access to more types of information and communications. **Do not use the Patient Portal for serious medical problems. For an Emergency please call 911**

**To be completed by the Patient or the Patient's/Client's/Resident's Legal Representative:**

I hereby consent to the above and acknowledge that a copy of the System's Privacy Notice was made available to me.

Name of Patient

Signature of Patient or Legal Representative

Name of Legal Representative (if signed by Legal Representative)

Authority of Legal Representative (e.g., Healthcare Proxy, Guardian, Parent)

Date Signed: ____/____/_____Time:_____

## To be completed by the Health Care Provider: (If above is unable to sign)

☐ **Patient Refused/Unable to Sign:** I or a representative of the Catholic Health System exercised a good faith effort to obtain the signature on the above acknowledgement from the patient named below. Our good faith efforts to obtain such signature included requesting that the patient sign this acknowledgement at the time we offered him/her with a copy of the System's Privacy Notice. Despite our good faith efforts, the patient failed or refused to sign the above acknowledgement.

☐ **Emergency:** Treatment was delivered during an emergency and, therefore, the Catholic Health System was not obligated to obtain the patient's signature on the above acknowledgment. If the patient did not previously receive a copy of the System's Privacy Notice, Patient will receive a copy with their discharge instruction or as soon as practicable after the emergency is resolved.

Name of System Representative

Signature of System Representative

Date Signed

Time

*FS0019*

Catholic Health

Diabetes Self-Management Education & Support Services

# Participant Self-Assessment of Diabetes Management

Please complete ***the unshaded areas*** of this form and ***return before first class*** via
Email: HealthConnection@chsbuffalo.org or Fax: (716) 706-2545
Please note that this information may be shared with your health care provider.

Name: _____ Instruction dates:_____

Date of birth: _____ Age: _____

___ Male ___ Female ___ Transgender man ___ Transgender woman ___ Non-binary/other

Phone/home:_____ Cell/work: _____

Physician: _____ Phone: _____

Endocrinologist:_____ Phone: _____

I verified my insurance coverage on: (date: _____)

Race/Ethnicity: ___ American Indian, Alaskan Native ___ Asian
___ Black ___ Hispanic/Latino or Spanish Origin
___ Middle Eastern or North African ___ Native Hawaiian/Other Pacific Islander
___ White ___ Other: _____

Language you prefer: ___ English ___ Other: _____

How confident are you filling out medical forms by yourself?
___ Extremely ___ Quite a bit ___ Somewhat ___ A little ___ Not at all

Do you have any difficulty with: ___ seeing ___ hearing ___ reading ___ speaking
other: _____ Please explain _____

Do you have any cultural or religious practices orbeliefs that influence how you care for your diabetes? ___Yes ___ No Please describe: _____

## Diabetes History:

What type of diabetes do you have?
___ Type 1 ___ Type 2 ___ Pre-diabetes ____Don't know

Year and age of diagnosis: _____

Do you have a history of Gestational Diabetes? ____ Yes ____ No

Does anyone in your family have diabetes? Who? _____

How would you rate your understanding of diabetes?

____ Good ____ Fair ____ Poor

Have you ever been instructed on diabetes care? ____ Yes ____ No

In your own words, what is diabetes?_____

Check all that apply:

- ☐ I am thinking about a healthy change: __ now __ in 30 days ___ in 6 months
- ☐ I have made a healthy change: ___ in the past 6 months ___ for 6 months +
- ☐ I do not plan to make any healthy changes this year

What is the hardest part about taking care of your diabetes?

_____

I feel good about my general health: ___ Agree ___ Neutral ___ Disagree

**Assessment**

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4

## Medical History

When was your last physical exam? _____

Do you have any of the following health problems or chronic complications?

___ heart ___ thyroid ___ kidney ___ history of DKA
___ high blood pressure ___ high cholesterol ___ eye problems
___ decreased circulation ___ digestive problems ___ depression
___ foot problems ___ sexual problems ___ numbness/pain
___ non-alcoholic fatty liver disease ___ arthritis, back, joint problems
___ Other: _____

Check any of the following tests/procedures you have had in the past 12 months:

___ dental exam ___ professional foot exam ___ A1c
___ dilated eye exam ___ urine test for protein ___ blood pressure
___ weight ___ cholesterol ___ flu shot ___ pneumonia shot

Do you check your feet regularly? ___ Yes ___ No

In the past 12 months have you gone to the ER or been admitted to a hospital for diabetes? ___ Yes ___ No
Do you snore? ___ Yes ___ No Feel tired after sleeping? ___ Yes ___ No
Do you smoke? ___ Yes ___ No If yes, how much? _____
Do you wear a medical identification? ___ Yes ___ No

**Needs:**

- ☐ Physical exam
- ☐ Dental exam
- ☐ Professional foot exam
- ☐ A1c
- ☐ Eye exam
- ☐ Urine test for protein
- ☐ Flu/pneumonia vaccine
- ☐ Cholesterol

## Monitoring

Do you test your own blood sugar at home? ___ Yes ___ No

When do you test? ___ before breakfast ___ before lunch/dinner
___ 2 hours after meals ___ at bedtime

**Assessment**

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ N/a

Usual results: _____ What is your target blood sugar?_____

What do you do with the results? _____

When have you had an A1c test at the lab?_____ Result: _____ %

How do you dispose of your lancets? _____

## Medication: Oral and Injectable

**Assessment**

List all meds taken (or attach list) _____

_____

_____

How often do you miss taking medications as prescribed?_____

If so, what did you do? _____

Did you miss the medication due to side effects? Explain: _____

_____

Allergies:_____

☐ 1
☐ 2
☐ 3
☐ 4
☐ N/a

For injectable medications:

Do you use: ___ vial and syringe ___ pen device ___ insulin pump

Where do you store your insulin? _____

What time do you inject your medication? _____

Where do you inject? _____

How do you dispose of your used needles? _____

☐ 1
☐ 2
☐ 3
☐ 4
☐ N/a

## Acute Complications:

**Assessment**

How often have you had low blood sugar (hypoglycemia, less than 70mg/dL) in the last month? _____

How did you feel? _____

How did you treat it? _____

Do you carry a source of fast acting sugar with you? ___ Yes ___ No

☐ 1
☐ 2
☐ 3
☐ 4
☐ N/a

## Physical Activity:

**Assessment**

Do you have any physical limitations? _____

Are you physically active (30+ minutes of exercise/day)? ___ Yes ___ No

Is your work physically active? ___ Yes ___ No

What, how long, and how often do you engage in physical activity:

_____

*It is recommended you have your provider's clearance prior to starting a new exercise regimen.*

☐ 1
☐ 2
☐ 3
☐ 4
☐ N/a

## Stress/coping:

**Assessment**

Is there anyone to help you with your diabetes? ___ Yes ___ No

From whom do you get support for your diabetes: _____

_____

What are your thoughts/feelings about having diabetes (burdened, angry, guilty, okay, etc.):_____

Do you have financial concerns regarding food, medicine, diabetes supplies? If yes, describe:_____

On a scale of 1 – 10, (1 being the lowest and 10 being the highest), how high would you rate your stress *related to your diabetes*? _____

☐ 1
☐ 2
☐ 3
☐ 4
☐ N/a

## Nutrition:

Height: _____ Weight: _____ Preferred weight: _____
Any weight changes? What/how much: _____
Are you following a special diet now? ___ Yes ___ No
If yes, what kind: _____

List any vitamins, supplements or herbs taken: _____
_____

How is your appetite? _____
Any cravings? ___ Yes ___ No For? _____

Who does the cooking? _____
How many times *a week* do you eat away from home:
___ fast food ___ restaurant ___ buffet ___ cafeteria

How is your food typically prepared? ___ fried ___ baked ___ broiled
How would you describe your portions? ___ small ___ medium ___ large

Any food allergies/intolerances: _____
Problems with: ___ chewing/swallowing ___ diarrhea
___ constipation ___ nausea/vomiting

How often do you consume on average ***per day***:
____ fruit ____ vegetables ____ desserts/sweets
Beverages: ___ coffee ___ tea ___ creamer ___ sugar
___ other sweetened drinks ___ juice ___ water
___ regular pop ___ diet pop ___ alcohol: _____

What eating concerns do you have? _____

What best describes your eating pattern? (Check all that apply)
_____ No set meal or snack times _____ Snack before bed
_____ Often skip breakfast or lunch _____ Snack in the afternoon
_____ Usually eat three meals per day _____ Snack or "graze" all day long

What time of day do you usually eat?
Breakfast: _____ Snack: _____ Lunch: _____ Snack: _____
Dinner: _____ Snack: _____

| Write down 5 ***favorite foods***: | Write down 5 ***typical snack choices***: |
|---|---|
| 1. | 1. |
| 2. | 2. |
| 3. | 3. |
| 4. | 4. |
| 5. | 5. |

**Assessment**
☐ 1
☐ 2
☐ 3
☐ 4
☐ N/a

## Individual Education Plan

Type of diabetes: ___ Type 1 ___ Type 2 ___ Pre-diabetes

Diabetes medications:_____

_____

| TOPIC | Pre Education Assessment | Post Education Assessment | PLAN |
|---|---|---|---|
| Healthy Eating/Nutrition | | | |
| Physical Activity | | | |
| Medications | | | |
| Monitoring | | | |
| Acute Complications | | | |
| Chronic Complications | | | |
| Problem Solving | | | |
| Healthy Coping | | | |

Patient/CDE Identified Learning Objective:

_____

_____

_____

Other education needs or methods to overcome barriers:

_____

_____

Educator(s):

_____ _____ _____
(name) (signature) (date)

_____ _____ _____
(name) (signature) (date)

**KEY:**

**Assessment:**

1- Needs education

2- Needs review

3- Comprehends key points

4- Demonstrates understanding

**Plan:**

1- Class

2- Individual Session

3- Support Services Referral

# Patients' Bill of Rights in a Hospital

**As a patient in a hospital in New York State, you have the right, consistent with law, to:**

(1) Understand and use these rights. If for any reason you do not understand or you need help, the hospital MUST provide assistance, including an interpreter.

(2) Receive treatment without discrimination as to race, color, religion, sex, gender identity, national origin, disability, sexual orientation, age or source of payment.

(3) Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.

(4) Receive emergency care if you need it.

(5) Be informed of the name and position of the doctor who will be in charge of your care in the hospital.

(6) Know the names, positions and functions of any hospital staff involved in your care and refuse their treatment, examination or observation.

(7) Identify a caregiver who will be included in your discharge planning and sharing of post-discharge care information or instruction.

(8) Receive complete information about your diagnosis, treatment and prognosis.

(9) Receive all the information that you need to give informed consent for any proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment.

(10) Receive all the information you need to give informed consent for an order not to resuscitate. You also have the right to designate an individual to give this consent for you if you are too ill to do so. If you would like additional information, please ask for a copy of the pamphlet "Deciding About Health Care — A Guide for Patients and Families."

(11) Refuse treatment and be told what effect this may have on your health.

(12) Refuse to take part in research. In deciding whether or not to participate, you have the right to a full explanation.

(13) Privacy while in the hospital and confidentiality of all information and records regarding your care.

(14) Participate in all decisions about your treatment and discharge from the hospital. The hospital must provide you with a written discharge plan and written description of how you can appeal your discharge.

(15) Review your medical record without charge and, obtain a copy of your medical record for which the hospital can charge a reasonable fee. You cannot be denied a copy solely because you cannot afford to pay.

(16) Receive an itemized bill and explanation of all charges.

(17) View a list of the hospital's standard charges for items and services and the health plans the hospital participates with.

(18) Challenge an unexpected bill through the Independent Dispute Resolution process.

(19) Complain without fear of reprisals about the care and services you are receiving and to have the hospital respond to you and if you request it, a written response. If you are not satisfied with the hospital's response, you can complain to the New York State Health Department. The hospital must provide you with the State Health Department telephone number.

(20) Authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors.

(21) Make known your wishes in regard to anatomical gifts. Persons sixteen years of age or older may document their consent to donate their organs, eyes and/or tissues, upon their death, by enrolling in the NYS Donate Life Registry or by documenting their authorization for organ and/or tissue donation in writing in a number of ways (such as a health care proxy, will, donor card, or other signed paper). The health care proxy is available from the hospital.

Public Health Law(PHL)2803 (1)(g)Patient's Rights, 10NYCRR, 405.7,405.7(a)(1),405.7(c)

**20. Family and Friends:** Under certain circumstances, the System may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your protected health information directly relevant to such person's involvement with your care or the payment for your care. The System may also use or disclose your protected health information to the previously named individuals as well as to a public or private entity authorized by law or by its charter to assist in disaster relief efforts to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, the following conditions will apply:

**a.** If you are present at or available prior to the use or disclosure of your protected health information, the System may use or disclose your protected health information if you agree, or if the System can reasonably infer from the circumstances, based on the exercise of its professional judgment, that you do not object to the use or disclosure.

**b.** If you are not present or are unable to agree or object to the use of disclosure because of incapacity or an emergency, the System will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the protected health information that is directly relevant to the person's involvement with your care.

**21. Required by Law.** In addition to those uses and disclosures listed above, we may use and disclose your protected health information if and to the extent we are required by law.

**C. YOUR RIGHTS:** You have the following rights regarding your protected health information:

**1. Right to Revoke an Authorization.** You may revoke an Authorization in writing, at any time. To request a revocation, you must submit a written request to the System's Privacy Officer, whose contact information is listed below.

**2. Right to Request Restrictions on Uses and/or Disclosures.** You may request restrictions on the use and/or disclosure of your protected health information for treatment, payment or health care operations. To request restrictions, you must submit a written request to the System's Privacy Officer. In your written request, you must identify the specific restriction requested. Except in limited circumstances, the System is not obligated to agree to any of your requested restrictions. If the System agrees to your requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide you with emergency treatment. Under certain circumstances, we may terminate our agreement to a restriction.

Requests submitted in writing for restriction of disclosure to a health plan for purposes of carrying out payment or healthcare operations will be honored provided the information pertains solely to a health care items or service paid for out-of-pocket by the individual unless prohibiting such disclosure is restricted by law.

**3. Right to Request Confidential Communications.** You may request to receive confidential communications of protected health information by alternative means or at alternative locations. You must make your request to the System's Privacy Officer. The System will accommodate all reasonable requests. We may condition this accommodation on your providing us with information as to how payment will be handled or by specifying an alternative address or other method of contact. We will not require you to provide an explanation for your request.

**4. Right to Inspect and Copy Information.** According to federal regulations, you may generally inspect and obtain a copy of your protected health information that we maintain in a designated record set. A "designated record set" is a group of records that include medical and billing records or other records that the System uses for making decisions about you. Under federal regulations, however, you have no right to inspect or copy certain records, including psychotherapy notes, information complied in reasonable anticipation of litigation. Please note that New York State's Mental Hygiene Laws and Public Health Law may provide you with independent rights to inspect and copy such information. If federal law does not allow you to inspect or copy certain information, such as psychotherapy notes, but State law allows you to inspect and copy such information, the System will respond to your request to access such information in accordance with New York State law. We may deny your request to inspect or copy your protected health information. Depending on the circumstances, you may or may not have a right to appeal our decision to deny your request. To inspect or copy your protected health information, you must submit a written request to the Health Information Management Department or Long Term Care Facility Administration. If you request a copy of your information, we may charge you a fee for the cost of copying and mailing your information and for other costs only as allowed by law.

If your protected health information is maintained in an EHR (Electronic Health Record) upon your written request, providing no other restrictions apply, you may obtain an electronic copy of such information and request that such a copy be transmitted directly to an entity or person designated by you. A fee may be charged for this service as allowed by law.

**5. Right to Amend your Information.** You may request that we amend your protected health information that we maintain in a designated record set. To request an amendment, you must submit a written request, along with a reason that supports your request to our Privacy Officer. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us. If you file such a statement, we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**6. Right to Receive an Accounting.** You may request an accounting of certain disclosures of your protected health information made by the System after April 14, 2003. We are not required to account for some disclosures, including those made for treatment, payment or health care operations. Additionally, we are not required to provide you with an accounting of disclosures that you authorize or with an accounting of some disclosures that we are permitted to make without your authorization. Your request for an accounting of disclosures must be submitted in writing to our Privacy Officer and must specify a time period to be covered by the accounting. You right to receive this information is subject to additional exceptions, restrictions and limitations.

**7. Right to Receive a Copy of Notice.** Upon your request, we will provide you with a paper copy of this Privacy Notice.

**8. Right to Notification of an Unauthorized Unsecured Breach.** In the case of a breach of unsecured protected health information, you or your next of kin (if individual is deceased) will be notified by mail or e-mail if the later is specified as preferred by you.

**9. Right to Complain.** You have the right to complain to the System or to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated. You may complain to the System by contacting the System's Privacy Officer, using the contact information below. You will not be retaliated against in any way for filing a complaint.

**10. Right to Receive Lab Reports.** Upon your request or your personal representative's request, the laboratory may provide you or your personal representative, and those persons specified under 45 CFR 164.524(c)(3)(ii), as applicable, with access to completed test reports that, using the laboratory's authentication process, can be identified as belonging to you.

**D. PRIVACY CONTACT**: The System's contact person for all issues regarding patient privacy and your rights under the federal privacy standards is the Privacy Officer. Questions regarding matters covered by this Notice shall be directed to the Privacy Officer. You may contact the privacy Officer at:

**Leonardo Sette-Camara, Esq.**
**Deputy Counsel, Corporate Compliance**
**& Privacy Officer**
**Administrative & Regional Training Center**
**144 Genesee St, Legal Services, 6th Floor**
**Buffalo, New York, 14203**

CHS-LS-PRIV-01-F01 Revised 11/4/08, 9/09, 2/10, 9/13, 11/14
Reviewed 8/16

# Catholic Health System
# Privacy Notice
# Effective April 14, 2003

(Revised 11/04/08, 2/17/2010, 09/17/2013; 11/11/2014)
Reviewed 8/16

**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.**

## A. OUR POLICY REGARDING YOUR HEALTH INFORMATION

We are committed to preserving the privacy and confidentiality of your health information. This Privacy Notice describes how the Catholic Health System ("The System") may use and disclose your protected health information according to applicable laws and regulations. It also describes your rights with respect to your protected health information. Your "protected health information" includes most information about your physical and mental health, such as symptoms, treatment, test results, and demographic data, which contains details that can be used to identify you, We are required by law to maintain the privacy of your "protected health information" and to provide you with this notice of your legal duties and privacy practices. The System's many components will comply with this Notice, including the System's hospitals, primary care, long term care, home care, ambulatory care, laboratories, chemical and physical rehabilitation, foundations and workforce members, including volunteers. Additionally, all health care providers who provide services for the System and within the System's facilities will comply with this Notice and will share your protected health information for treatment, payment and healthcare operations (as defined herein.)

We reserve the right to change this notice and to make the revised notice effective for all protected health information that we maintain at that time and any information we may receive in the future. We will post a copy of the current notice in our facilities and we will make any revised notice available at the facilities for you to request a copy. We are required to abide by the terms of this notice while it remains in effect, as required or authorized by law.

## B. USES AND DISCLOSURES WITH AND WITHOUT YOUR AUTHORIZATION

We must obtain your written permission or "authorization" to use or disclose your protected health information except in the limited situations listed below, which do not require your written authorization:

**1. Treatment.** We will use and disclose your protected health information to provide, coordinate and manage your health care and related services. We may disclose your protected health information to health care providers, including providers not affiliated with The System, so that they may provide you with treatment. For example, we may disclose your protected health information to a pharmacy to fill a prescription, to a laboratory to order a test, or a specialist for consultation.

**2. Payment.** We will use and disclose your protected health information, as needed, for the System to obtain payment for our health care services. For example, we may disclose protected health information to your health insurance company so we may obtain prior approval for a surgery, to determine whether you are eligible for benefits or to determine whether a particular service is covered under you plan. We may disclose your protected health information to other health care providers, health plans, and health care clearinghouses for their payment activities. For example, we may disclose protected health information to anesthesia care providers so that they may obtain payment for their services.

**3. Health Care Operations:** We will use and disclose your protected health information for our health care operations. For example, we may use your protected health information to evaluate the performance of the System's personnel and to perform licensing, training, and accreditation activities. In certain situations, we may also disclose your protected health information to another health care provider, health plan, or health care clearinghouse who has or had a relationship with you, for the purpose of that entity's health care operations, as long as the protected health information is related to your relationship with that entity. For example, the System may disclose your protected health information to allow another entity to conduct activities to determine whether they have provided quality services, to review the performance and qualifications of health care providers, to conduct training programs, and to perform accreditation, certification, licensing or credentialing activities.

**4. Law Enforcement Purposes.** We may disclose your protected health information to law enforcement officials under certain circumstances when we are required or permitted by law to disclose such information. For example, we may disclose your protected health information if we are required by law to report a certain type of wound or injury, such as a gun-shot wound. We may also disclose your protected health information pursuant to an order, warrant, subpoena or summons issued by a judicial officer. Under certain circumstances, we may disclose your protected health information pursuant to administrative requests related to law enforcement purposes. We may disclose limited protected health information to law enforcement officials upon their request to assist them in identifying or locating a suspect, fugitive, material witness or missing person.

Additionally, under certain circumstances we may disclose your protected health information to law enforcement official's request about a victim of a crime or in order to report evidence of criminal conduct that occurred on our premises.

**5. Public Health Activities.** The System may disclose your protected health information to certain public health authorities and others according to specific rules that apply to public health activities. For example, the System may disclose your protected health information to public health authorities or other government authorities authorized by law to receive such information for purposes of preventing or controlling disease, injury, disability, or child abuse or neglect or for the conduct of public health surveillance, investigations and interventions. We may also disclose your protected health information to certain individuals subject to the jurisdiction of the Food and Drug Administration FDA-regulated products or activities, to certain individuals who may be at risk of contracting or spreading a disease or condition, and under certain circumstances to your employer if we have provided health care to you at your employer's request.

**6. Health Oversight Activities.** The System may disclose your protected health information to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations, proceedings and actions; inspections; licensure or disciplinary actions; and other activities necessary for appropriate oversight of the health care system and oversight of certain programs and entities as authorized by law.

**7. Judicial and Administrative Proceedings.** We may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order. In certain circumstances, we may disclose your protected health information in response to a subpoena, discovery request or other lawful process to the extent authorized by state law if we receive satisfactory assurances from the party requesting your information that you have been notified of the request or that they have made reasonable efforts to obtain a qualified protective order. A qualified protected order is an order of a court or tribunal that prohibits the use or disclosure of your protected health information for any purpose other than the proceeding for which it was requested and which requires that your protected health information will be returned to the System at the end of the proceeding.

**8. Specialized Government Functions.** In certain circumstances, federal regulations authorize the System to use and/or disclose your protected health information for specialized government functions. If you are a member of the armed forces, the System may use and disclose your protected health information as directed by appropriate military authorities. We may disclose your protected health information to authorized federal officials for certain national security and intelligence activities and to protect the President of the United States and other dignitaries. The System may also disclose your protected health information to law enforcement personnel or to a correctional institution if such information is required for the health and safety of inmates, law enforcement personnel, individuals at the correctional institution, or individuals responsible for transporting inmates or if such information is required to maintain safety, law and order at a correctional institution.

**9. Suspected Abuse, Neglect or Domestic Violence.** The System will disclose medical information that reveals that you may be a victim of abuse, neglect or domestic violence to a government authority if the System is required by law to make such disclosure. For example, state law requires health care professionals to report cases of suspected, child abuse or maltreatment. If the System is authorized, but not required, by law to disclose evidence of suspected abuse, neglect or domestic violence, it will do so if it believes that the disclosure is necessary to prevent serious harm, or if you are incapacitated and government officials need such information for an immediate law enforcement activity.

**10. To Avert Serious Threat to Health or Safety.** The System may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is made to an individual who is reasonably able to prevent or lessen the threat.

**11. Research.** We may use and disclose your protected health information for research as long as such research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to preserve the privacy of your protected health information. For example, a research project may involve comparing the health of patients who received one treatment to those who received another treatment for the same condition. Before we use or disclose protected health information for research purposes, the research project will go through a special review and approval process. Even without special approval, however, we may permit researchers to review your protected health information if it is necessary to help them prepare for a research project, as long as they do not remove or take a copy of any protected health information.

**12. Medical Examiners, Funeral Directors, and Organ Donation.** The System may disclose your protected health information to a medical examiner for identification purposes, to determine the cause of death or for other purposes authorized by law. We may also disclose your protected health information to a funeral director, as authorized by law, to permit the funeral director to carry out his or her duties. Additional, the System may use and disclose your protected health information for the purpose of arranging for cadaveric organ, eye, or tissue donation and transplantation.

**13. Worker's Compensation.** The facility may disclose your protected health information, as authorized by and in compliance with worker's compensation laws.

**14. Appointment Reminders.** The System may, from time to time, use or disclose your protected health information to contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that we believe may be of interest to you. The System may remind you of appointments by mailing a postcard to you at the address provided by you or by telephoning your home and leaving a message on your answering machine or with the individual answering the phone. The System will not disclose any information with these appointment reminders except your name, your address and the time, date and location of your appointment.

**15. Fundraising.** The System may use limited protected health information for fundraising purposes and may disclose such information to its Business Associates and to institutionally related foundations for assistance in raising funds for the System. The System may contact you for the purpose of raising money for the System, but you have the right to opt out of receiving fundraising communications. Any fundraising communication sent will contain information on how recipients may opt out of future communication of this type.

**16. De-identified Information.** The System may de-identify your protected health information according to specific federal rules so that the information does not identify you and cannot be used to identify you. The System may use and disclose your de-identified information. The System may also partly de-identify your protected health information by removing your name, address, telephone number and many other identifying factors to create a "limited data set", which may be used and disclosed for research purposes. Your protected health information will only be disclosed in the form of a "limited data set" to recipients who sign an agreement to use your protected health information for specific purposes according to law and who agree not to identify you.

**17. Patient Directory.** Unless you object, the System may use your name, location, general condition and religious affiliation to maintain the System's patient directory and may disclose such information to members of the clergy and (except for religious affiliation) to individuals who ask for you by name.

**18. Business Associates.** The System may disclose your protected health information to a business associate of the System if we obtain satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your protected health information. A "business associate" is an entity that provides certain services to the System or assists the System in undertaking some functions, such as a billing company that assists the System in submitting claims for payment to insurance companies. Security provisions that legally apply to the System are also applied to our business associates.

**19. Personal Representatives.** The System may disclose your protected health information to or according to the direction of a person who, under applicable law, has the authority to represent you in making decisions related to your health. For example, we may disclose your protected health information to an agent who you authorized through a health care proxy form to make health care decisions for you in the event that you should become unable to make your own health care decisions.