



NEW YORK UNIVERSITY SCHOOL OF MEDICINE

Department of Urology

Urology Associates

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150 East 32nd Street, 2nd Floor
New York, NY 10016
Telephone: (646) 825-6300
Facsimile: (646) 825-6399

Dear Patient,

To ensure that your visit goes well, please have the following documents faxed to: 646-825-6369.

1. Completed Registration Forms *
2. Biopsy Report *
3. PSA History *
4. CT Scan Reports (only if one was done)
5. Bone Scan Reports(only if one was done)
6. Name, address, phone number of your referring physician/urologist
7. Copy of insurance card*
8. Biopsy slides (only if available)

You can also send the above by email to: lisa.watson@nyumc.org

Please also bring a copy of these records with you on the day of your appointment.

We look forward to taking care of you.

Lisa Watson-Monderson
646-825-6327

* Mandatory Items



NYU UROLOGY ASSOCIATES

Christopher Kelly, MD Andrew McCullough, MD Herbert Lepor, MD
Victor Nitti, MD Nirit Rosenblum, MD Ojas Shah, MD Ellen Shapiro, MD
Michael Stifelman, MD Samir Taneja, MD William Huang, MD

Infinity ID# _____

PATIENT NAME: _____ Social Security: _____

DATE OF BIRTH: _____ BIRTH PLACE: _____ SEX: M F

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE #: (____) _____ WORK #: (____) _____

Employer & Address: _____

Primary Care Doctor: _____ Phone # (____) _____

Primary Care Doctor's Address : _____ Fax # (____) _____

Referral Source (if different from above) _____

Address & Phone Number: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Insurance Information

INSURANCE CO. NAME: _____ ID #: _____

Group # _____ Policy # _____ TEL: (____) _____

CLAIMS ADDRESS: _____

POLICY HOLDER'S NAME: _____ DOB: _____ GENDER: M F

Secondary Insurance Information

INSURANCE CO. NAME: _____ ID #: _____

Group # _____ Policy # _____ TEL: (____) _____

CLAIMS ADDRESS: _____

POLICY HOLDER'S NAME: _____ DOB: _____ GENDER: M F

RESPONSIBLE PARTY (if other than patient or patient is a minor)

Name : _____ Home Phone: (____) _____

Address: _____ Work Phone: (____) _____

City: _____ State: _____ Zip: _____ Relationship to patient: _____

I CONSENT TO TREATMENT NECESSARY FOR THE CARE OF THE ABOVE NAMED PATIENT. I AUTHORIZE THE RELEASE OF ALL MEDICAL RECORDS TO REFERRING PHYSICIAN(S) AND MY INSURANCE COMPANY IF APPLICABLE. I WILL ALLOW FAX TRANSMITTAL OF MEDICAL RECORDS IF NECESSARY. I ACKNOWLEDGE FULL FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED AND UNDERSTAND THAT PAYMENT IS DUE AT TIME OF SERVICE. I AUTHORIZE AND REQUEST THAT PAYMENT BE MADE DIRECTLY TO NYU UROLOGY ASSOCIATES SHOULD THEY ELECT TO RECEIVE SUCH PAYMENT. I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT FOR TREATMENT, FINANCIAL RESPONSIBILITY, RELEASE OR MEDICAL DATA AND INSURANCE AUTHORIZATION.

SIGNATURE: _____ DATE: _____

REVIEWED BY: _____

(PATIENT COMPLETES UNSHADED AREAS ONLY)

PATIENT NAME: _____ DATE: _____

PHYSICIAN NAME: _____ REFERRING DOCTOR: _____

PROBLEM _____

HPI(For Physician use only)

<u>Medical Illnesses:</u>	<u>Medications:</u>
Hypertension _____	_____
Infectious Diseases _____	_____
Diabetes _____	_____
Heart Disease _____	
Seizures _____	<u>Allergies:</u> _____
Kidney Stones _____	_____
Bleeding Disorders _____	_____
Other _____	_____
Operations/Surgeries _____	

Physician use only: (Comments/Notes)

Family History:

Prostate Cancer _____ Kidney Stone _____

Heart Attacks _____ High Blood Pressure _____

Anesthesia _____ Kidney Failure _____

Physician use only: (Comments/Notes)

Social History

Married _____ Partnered _____ Single _____ Divorced _____

Children _____ How Many? _____

Alcohol _____ How Much? _____

Cigarettes? _____ How Many? _____ (packs per day _____) How Long? _____

Physician use only: (Comments/Notes)

Patient Name: _____

Date: _____

Review of Systems

Do you now or have you ever had any problems related to the following systems? Circle Yes or No.

Please explain any Yes answers in the space provided.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other:		

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N
Other:		

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/Tingling	Y	N
Other:		

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N
Other:		

Eyes

Blurred Vision	Y	N
Double Vision	Y	N
Pain	Y	N
Other:		

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Other:		

Ear/Nose/Throat/Mouth

Ear infection	Y	N
Sore throat	Y	N
Sinus problem	Y	N
Other:		

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N
Other:		

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
Other:		

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Other:		

Last Menstrual Period: _____

Physician use only (Comments/Notes)

Urinary Symptoms (Circle the correct answer)	NOT AT ALL	LESS THAN 1 TIME IN 5	LESS THAN HALF THE TIME	ABOUT HALF THE TIME	MORE THAN HALF THE TIME	ALMOST ALWAYS
Over the past month, how often have you had a sensation of not emptying your bladder completely after your finished urinating?	0	1	2	3	4	5
Over the past month, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5
Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0 none	1 1 time	2 2 times	3 3 times	4 4 time	5 5 or more

Quality of Life Due to Urinary Problems (Circle the correct answer)					
1. Over the past month, how much physical discomfort did urinary problems cause you?	none 0	only a little 1	some 2	a lot 3	
2. Over the past month, how much did you worry about your health because of urinary problems?	none 0	only a little 1	some 2	a lot 3	
3. Overall, how bothersome has any trouble with urination been during the past month?	not at all bothersome 0	bothers me a little 1	bothers me some 2	bothers me a lot 3	
4. If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that? 0 = Delighted 1 = Pleased 2 = Mostly satisfied 3 = Mixed (about equally satisfied and dissatisfied) 4 = Mostly dissatisfied 5 = Unhappy 6 = Terrible					
5. Over the past month, how much of the time has any urinary problem kept you from doing the kinds of things you would usually do?	none of the time 0	a little of the time 1	some of the time 2	most of the time 3	all of the time 4

Problems Due to Symptoms (Circle the correct answer)	NO PROBLEM	VERY SMALL PROBLEM	SMALL PROBLEM	MEDIUM PROBLEM	BIG PROBLEM
Over the past month, how much has a sensation of not emptying your bladder been a problem for you?	0	1	2	3	4
Over the past month, how much has frequent urination during the day been a problem for you?	0	1	2	3	4
Over the past month, how much has getting up at night to urinate been a problem for you?	0	1	2	3	4
Over the past month, how much has stopping and starting when you urinate been a problem for you?	0	1	2	3	4
Over the past month, how often has a need to urinate with little warning been a problem for you?	0	1	2	3	4
Over the past month, how much has impaired sized and force of urinary stream been a problem for you?	0	1	2	3	4
Over the past month, how much has having to push or strain to begin urination been a problem for you?	0	1	2	3	4

OFFICE MEDICAL RECORD # _____ NAME _____

I. PREOPERATIVE DATA (to be completed by patient)

Name _____

Date of Birth _____ Age _____

Occupation _____

Home Phone Number _____ Work Phone Number _____

Fax Number _____

Email Address _____

Home Address Street _____

City _____ State _____ Zip _____

Height _____

Weight _____

How may the office correspond with you regarding confidential medical information?
(if applicable, check more than one option)

Phone _____

Mail _____

Fax _____

Email _____

Marital Status:

Single _____

Married _____

Widower _____

Separated _____

Divorced _____

Race:

Caucasian _____

Hispanic _____

African American _____

Asian _____

Other _____

Number of first degree relatives (brother, father, grandfather) with prostate cancer

0 _____

1 _____

2 _____

≥ 3 _____

II BASELINE URINARY FUNCTION ASSESSMENT (to be completed by patient)

Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?

- not at all
- less than 1 time in 5
- less than half the time
- about half the time
- more than half the time
- almost always

Over the past month, how often have you had to urinate again less than two hours after you finished urinating?

- not at all
- less than 1 time in 5
- less than half the time
- about half the time
- more than half the time
- almost always

Over the past month, how often have you found you stopped and started again several times when you urinated?

- not at all
- less than 1 time in 5
- less than half the time
- about half the time
- more than half the time
- almost always

Over the past month, how often have you found it difficult to postpone urination?

- not at all
- less than 1 time in 5
- less than half the time
- about half the time
- more than half the time
- almost always

Over the past month, how often have you had a weak urinary stream?

- not at all
- less than 1 time in 5
- less than half the time
- about half the time
- more than half the time
- almost always

Over the past month, how often have you had to push or strain to begin urination?

- not at all
- less than 1 time in 5
- less than half the time
- about half the time
- more than half the time
- almost always

Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?

- not at all
- 1 time
- 2 times
- 3 times
- 4 times
- 5 or more times

If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?

- delighted
- pleased
- mostly satisfied
- mixed (about equally satisfied and dissatisfied)
- mostly dissatisfied
- unhappy
- terrible

Over the past 4 weeks, how often have you leaked urine?

- every day
- about once a week
- less than once a week
- not at all

Which of the following best describes your urinary control **during the last 4 weeks?**

- no control whatsoever
- frequent dribbling
- occasional dribbling
- total control

How many pads or adult diapers per day did you usually use to control leakage **during the last 4 weeks?**

- 3 or more pads per day
- 2 pads per day
- 1 pad per day
- No pads

How big a problem, if any, has each of the following been for you **during the last 4 weeks?**

Dripping urine or wetting your pants:

- no problem
- very small problem
- small problem
- moderate problem
- big problem

Urine leakage interfering with your sexual activity:

- no problem
- very small problem
- small problem
- moderate problem
- big problem

Overall, how big a problem has your urinary function been for you **during the last 4 weeks?**

- no problem
- very small problem
- small problem
- moderate problem
- big problem

Do you consider yourself continent? **(must select one of the following):**

- continent
- incontinent

Have you ever had an **inguinal hernia** repair?

- yes
- no

If **yes**, was the hernia repair on the

- left right bilateral

If you had the inguinal hernia repair, when was it?

_____ / _____ (mm/yy)

III BASELINE ERECTILE FUNCTION ASSESSMENT (to be completed by patient)

How would you rate each of the following **during the last 4 weeks?**

Your level of sexual desire?

- very poor
- poor
- fair
- good
- very good

Your ability to have an erection?
(climax)?

- very poor
- poor
- fair
- good
- very good

Your ability to reach orgasm

- very poor
- poor
- fair
- good
- very good

Rate your erection **without** the use of Viagra or Cialis (a score of 100% represents an erection satisfactory for intercourse and a score of 0% represents a total absence of erection or fullness)

- 0%
- 25%
- 50%
- 75%
- 100%

Rate your erection **with** use of Viagra or Cialis (a score of 100% represents an erection satisfactory for intercourse and a score of 0% represents a total absence of erection or fullness)

- none
- 25%
- 50%
- 75%
- 100%

How would you describe the FREQUENCY of your erections?

- I NEVER had an erection when I wanted one
- I had an erection LESS THAN HALF the time I wanted one
- I had an erection ABOUT HALF the time I wanted one
- I had an erection MORE THAN HALF the time I wanted one
- I had an erection WHENEVER I wanted one

How often have you awakened in the morning or night with an erection?

- never
- seldom (less than 25% of the time)
- not often (less than half of the time)
- often (more than half of the time)
- very often (more than 75% of the time)

During the last 4 weeks, did you have vaginal or anal intercourse?

- no
- yes
- once
- more than once

Overall, how would you rate your ability to function sexually **during the last 4 weeks?**

- very poor
- poor
- fair
- good
- very good

Overall, how big a problem has getting and maintaining an erection been for you **during the last 4 weeks?**

- no problem
- very small problem
- small problem
- moderate problem
- big problem



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Payment Policy

NYU Urology Associates participates in many health insurance plans that provide benefits for the treatment we render to our patients. But even when our practice is identified as participating in your health plan, it is important for you to know that the extent of coverage for any particular treatment may vary between health plan packages and even between employee groups covered by the same benefit program.

We will cooperate with your insurance plan to supply the necessary information and obtain authorizations when appropriate. However, it is important for you to know your financial obligations and understand that they may range from a small co-payment or coinsurance amount for an office visit or service, to the full charge for a procedure that is not covered by health insurance. You should contact your insurance company if you have questions related to a specific treatment, associated coverage and your financial obligations.

If you do not have insurance, or NYU Urology Associates does not participate in your plan, you are responsible for full payment of all charges incurred on the day you receive the services.

You may be required to make a deposit prior to your surgery. The surgical fee is only an estimate subject to change based on the physician's findings and surgical plan at the time of surgery. Once the surgery has been performed and your insurance company has made payments you may be entitled to a refund. This refund will be mailed to you after all services related to the surgery (pre-operative and post-operative) have been paid in full.

For your convenience, we accept payment in the form of cash, check., MasterCard, Visa and American Express. If you have concerns about your ability to pay for treatment as required by NYU Urology Associates, please ask to speak with our Business Manager before treatment is rendered.

Thank you for choosing NYU Urology Associates for your health care needs. If you have additional questions regarding your financial obligations for the services you received from us, please contact us directly.

I have read and understand this financial policy, and I accept responsibility for my financial obligations related to treatment rendered by NYU Urology Associates I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature: _____ Date: _____

Name (Please Print): _____



New York University
A private University in the public service



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.

WHY ARE YOU GETTING THIS NOTICE?

NYU School of Medicine is required by federal and state law to maintain the privacy of your health information. The use and disclosure of your health information is governed by regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the requirements of applicable New York State law. For health information covered by HIPAA, the NYU School of Medicine is required to provide you with this Notice and will abide by this Notice with respect to such health information. If you have questions about this Notice, please contact our Privacy Officer at 877-360-7626.

We will ask you to sign an “acknowledgment” indicating that you have been provided with this notice.

WHO FOLLOWS THE POLICIES IN THIS NOTICE?

The privacy practices described in this notice are followed by:

Any health care professional who treats you at any of our School of Medicine locations, including our Faculty Group Practices.

All employees, trainees, students, or volunteers providing services at any of our School of Medicine locations, including our Faculty Group Practices.

Any business associates of the School of Medicine, including our Faculty Group Practices (See Paragraph 1f on page 4 for a description of business associates.)

WHAT HEALTH INFORMATION IS PROTECTED?

We are committed to protecting the privacy of information we gather about you while providing health-related services. Some examples of protected health information are:

Information indicating that you are a patient receiving treatment or other health-related services from our physicians or staff (including at our Faculty Group Practices);

Information about your health condition (such as a disease you may have);

Information about health care products or services you have received or may receive in the future (such as an operation); or

Information about your health care benefits under an insurance plan (such as whether a prescription is

covered);

when combined with:

Demographic information (such as your name, address, or insurance status);

Unique numbers that may identify you (such as your social security number, your phone number, or your driver's license number); and

Other types of information that may identify who you are.

If you have any questions about this notice or would like further information, please contact your doctor's office.



SUMMARY OF THIS NOTICE

This summary includes references to paragraphs throughout this notice that you may read for additional information.

- 1. Written Authorization Requirement.** We may use your health information or share it with others in order to treat your condition, obtain payment for that treatment, and run our business operations. (See paragraph 1 on page 4, Treatment, Payment and Business Operations.) We generally need your written authorization for other uses and disclosures of your health information, unless an exception described in this Notice applies.
- 2. Authorizing Transfer of Your Records.** You may request that we transfer your records to another person or organization by completing a written authorization form. This form will specify what information is being released, to whom, and for what purpose. The authorization will have an expiration date.
- 3. Canceling Your Written Authorization.** If you provide us with written authorization, you may revoke, or cancel, it at any time, except to the extent that we have already relied upon it. To revoke a written authorization, please write to the doctor's office where you initially gave your authorization.
- 4. Exceptions to Written Authorization Requirement.** There are some situations in which we do not need your written authorization before using your health information or sharing it with others. (See paragraphs 2 through 9). They include:

Treatment, Payment and Operations. As mentioned above, we may use your health information or share it with others in order to treat your condition, obtain payment for that treatment, and run our business operations. (See paragraph 1 on page 4).

Family and Friends. If you do not object, we will share information about your health with family and friends involved in your care. (See paragraph 2 on page 6)

Research. Although we will generally try to obtain your written authorization before using your health information for research purposes, there may be certain situations in which we are not required to obtain your written authorization. (See paragraph 3 on page 5)

De-identified Information. We may use or disclose your health information if we have removed any information that might identify you. When all identifying information is removed, we say that the health information is "completely de-identified." We may also use and disclose "partially de-identified" information if the person who will receive it agrees in writing to protect your privacy when using the information. (See paragraph 4 on page 6.)

Incidental Disclosures. We may inadvertently use or disclose your health information despite having taken all reasonable precautions to protect the privacy and confidentiality of your health information. (See paragraph 5 on page 6).

Emergencies or Public Need. We may use or disclose your health information in an emergency or for important public health needs. For example, we may share your information with public health officials at the New York State or city health departments who are authorized to investigate and control the spread of diseases. (See paragraph 6 on page 6.)

- 5. How To Access Your Health Information.** You generally have the right to inspect and get copies of your health information. (See paragraph 1 on page 8.)
- 6. How To Correct Your Health Information.** You have the right to request that we amend your health information if you believe it is inaccurate or incomplete. (See paragraph 2 on page 9.)

7. How To Identify Others Who Have Received Your Health Information.



You have the right to receive an "accounting of disclosures." This is a report that identifies certain persons or organizations to which we have disclosed your health information. All disclosures are made according to the protections described in this Notice of Privacy Practices. Many routine disclosures we make (for treatment, payment, or business operations among others) will not be included in this report. However, it will identify many

non-routine disclosures of your information. (See paragraph 3 on page 9.)

8. **How to Request Additional Privacy Protections.** You have the right to request further restrictions on the way we use your health information or share it with others. However, we are not required to agree to the restriction you request. If we do agree with your request, we will be bound by our agreement. (See paragraph 4 on page 10.)
9. **How To Request Alternative Communications.** You have the right to request that we contact you in a way that is more confidential for you, such as at home instead of at work. We will try to accommodate all reasonable requests. (See paragraph 5 on page 11.)
10. **How Someone May Act On Your Behalf.** You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors unless the minors are permitted by law to act on their own behalf.
11. **How to Learn about Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information.** Special privacy protections apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, psychotherapy notes and genetic information. (See paragraph 2 on page 8).
12. **How To Obtain A Copy of This Notice.** If you have not already received one, you have the right to a paper copy of this notice. You may request a paper copy at any time, even if you have previously agreed to receive this notice electronically. You can request a copy of the privacy notice directly from your doctor's office. You may also obtain a copy of this notice from our website at www.med.nyu.edu or by requesting a copy at your next visit.
13. **How To Obtain A Copy of Revised Notice.** We may change our privacy practices from time to time. If we do, we will revise this notice so you will have an accurate summary of our practices. You will be able to obtain your own copy of the revised notice by accessing our website at www.med.nyu.edu or by calling your doctor's office. You may also ask for one at the time of your next visit. The effective date of the notice is noted in the top right corner of each page. We are required to abide by the terms of the notice that is currently in effect.
14. **How To File A Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the United States. Department of Health and Human Services. To file a complaint with us, please contact our Privacy Officer at 877-360-7626.

No one will retaliate or take action against you for filing a complaint.



HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION

1. Treatment, Payment, and Business Operations

We may use your health information or share it with others in order to treat your condition, obtain payment for that treatment, and run our business operations.

a. Treatment.

We may share your health information with doctors or nurses who are involved in taking care of you. They may, in turn, use that information to diagnose or treat you. A doctor may share your health information with another doctor inside our hospital, or with a doctor at another hospital, to determine how to diagnose or treat you. We may also share your health information with other doctors who referred you to us and/or to whom you have been referred for further health care.

b. Payment.

We may use your health information or share it with others so that we may obtain payment for your health care services. For example, we may share information about you with your health insurance company. This will help us obtain reimbursement after we have treated you, or determine whether your health insurance will cover your treatment. We might also need to inform your health insurance company about your health condition in order to obtain pre-approval for your treatment, such as admitting you to the hospital for a particular type of surgery. Finally, we may share your information with other health care providers and payers for their payment activities. We may ask for your consent to use or disclose your health information for some or all of these payment activities.

c. Business Operations.

We may use your health information or share it with others in order to conduct our business operations. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use it to educate our staff or medical students and other health care students on how to improve the care they provide for you.

We may also share your health information with other health care providers to help them with their business operations.

d. Appointment Reminders, Treatment Alternatives, Benefits, and Services. In the course of providing treatment to you, we may use your health information to contact you with a reminder that you have an appointment for treatment or services at our facility. We may also use your health information in order to recommend possible treatment alternatives or health-related benefits and services that may be of interest to you.

e. Fundraising.

To support our business operations, we may use demographic information about you, and the dates that you received treatment or services, in order to contact you to raise money to help us operate. Examples of demographic information include information about your age and gender, where you live or work, and the dates that you received treatment.

Because of the close affiliation between NYU Hospitals Center and the NYU School of Medicine, you may be contacted by either the Hospital or the School, and the health information described above may be shared between the Hospital and the School to carry out joint fundraising activities



f. Education.

The close affiliation established between NYU Hospitals Center and the NYU School of Medicine serves to provide high quality training and education to the health care professionals at both institutions as well as the School's students. This affiliation also offers patients the benefits of receiving care from doctors and other health care professionals who are leaders in research and the development of other advanced treatment therapies. As part of this close affiliation, we may share your health information with health care professionals, medical staff members, employees, trainees, volunteers and other staff members at the NYU Hospitals Center for the Hospital's and School's joint training and education activities.

g. Business Associates.

We may disclose your health information to contractors, agents and other business associates who need the information in order to assist us with obtaining payment or carrying out our business operations. For example, we may share your health information with a billing company that helps us to obtain payment from your insurance company.

Another example is that we may share your health information with an insurance company, law firm, or a risk management organization in order to obtain professional advice about how to manage risk and legal liability, including insurance or legal claims. We may also share your health information with an accounting firm.

If we do disclose your health information to a business associate, we will have a written contract to

ensure that our business associate also protects the privacy of your health information.

h. Electronic Communications.

In order to communicate information in order to treat you, obtain payment for services, or conduct our business operations, our staff may communicate information about you via email over our network. However, you will not be contacted by email unless we have obtained your authorization to do so, or we are responding to an inquiry that you initiated via email.

2. Family and Friends Involved in Your Care

If you do not object, we may share your health information with a family member, relative, or close personal friend who is involved in your care or payment for that care. We may also notify a family member, personal representative, or another person responsible for your care about your location and general condition here at the School of Medicine. In some cases, we may need to share your information with a disaster relief organization that will help us notify these persons.

3. Research.

In most cases, we will ask for your written authorization before using your health information or sharing it with others in order to conduct research. However, under some circumstances, we may use and disclose your health information without your written authorization. To do this, we are required to obtain approval through a special process to ensure that research without your written authorization poses minimal risk to your privacy. Under no circumstances, however, would we allow researchers to use your name or identity publicly.

We may also release your health information without your written authorization to people who are preparing a future research project, so long as any information identifying you does not leave our facility. In the unfortunate event of your death, we may share your health information with people who are conducting research using the information of deceased persons, as long as they agree not to remove from our facility any information that identifies you.



4. Completely De-identified or Partially De-identified Information.

We may use and disclose your health information if we have removed any information that has the potential to identify you, so that the health information is “completely de-identified.” We may also use and disclose “partially de-identified” health information about you for certain purposes if the person who will receive the information signs an agreement to protect the privacy of the information as required by federal and state law. Partially de-identified health information will *not* contain any information that would directly identify you (such as your name, street address, social security number, phone number, fax number, electronic mail address, website address, or license number). R&G Comment: partially de-identified information (referred to as a “limited data set” under the regulations) may be disclosed only for public health, research, or health care operations purposes.

5. Incidental Disclosures

While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other patients in the treatment area may see, or overhear discussion of, your health information.

6. Public Need

a. As Required By Law.

We may use or disclose your health information if we are required by law to do so. We also will notify you of these uses and disclosures if notice is required by law.

b. Public Health Activities.

We may disclose your health information to authorized public health officials (or a foreign government agency collaborating with such officials) so they may carry out their public health activities. For example, we may share your health information with government officials who are responsible for controlling disease, injury, or disability.

We may also disclose your health information to a person who may have been exposed to a communicable

disease or be at risk for contracting or spreading the disease, if a law permits us to do so. And finally, we may release some health information about you to your employer if your employer hires us to provide you with a physical exam. This could happen if we were to discover that you have a work-related injury or disease that your employer must know about in order to comply with employment laws.

c. Victims of Abuse, Neglect, or Domestic Violence.

We may release your health information to a public health authority or other authorized governmental authority if we reasonably believe you have been a victim of abuse, neglect, or domestic violence. We will make every effort to obtain your permission before releasing this information, but in some cases we may be required or authorized to act without your permission.

d. Health Oversight Activities.

We may release your health information to government agencies authorized to conduct audits, investigations, and inspections of our facility. These government agencies monitor the operation of the health care system, government benefit programs such as Medicare and Medicaid, and compliance with government regulatory programs and civil rights laws.

e. Product Monitoring, Repair, and Recall.

We may disclose your health information to a person or company that is regulated by the Food and Drug Administration for the purpose of: (1) reporting or tracking product defects or problems; (2) repairing, replacing, or recalling defective or dangerous products; or (3) monitoring the performance of a product after it has been approved for use by the general public.



f. Lawsuits and Disputes.

We may disclose your health information if we are ordered to do so by a court or administrative tribunal that is handling a lawsuit or other dispute.

g. Law Enforcement.

We may disclose your health information to law enforcement officials for the following reasons:

To comply with court orders or laws that we are required to follow;

To assist law enforcement officers with identifying or locating a suspect, fugitive, witness, or missing person;

If you have been the victim of a crime and we determine that: (1) we have been unable to obtain your agreement because of an emergency or your incapacity; (2) law enforcement officials need this information immediately to carry out their law enforcement duties; and (3) in our professional judgment disclosure to these officers is in your best interests;

If we suspect that your death resulted from criminal conduct;

If necessary to report a crime that occurred on our property; or

If necessary to report a crime discovered during an offsite medical emergency (for example, by emergency medical technicians at the scene of a crime).

h. To Avert A Serious And Imminent Threat to Health or Safety.

We may use your health information or share it with others when necessary to prevent a serious and imminent threat to your health or safety, or the health or safety of another person or the public. In such cases, we will only share your information with someone able to help prevent the threat. We may also disclose your health information to law enforcement officers: 1) if you tell us that you participated in a violent crime that may have caused serious physical harm to another person (unless you admitted that fact while in counseling), or 2) if we determine that you escaped from lawful custody (such as a prison or mental health institution).

i. National Security and Intelligence Activities or Protective Services.

We may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials.

j. Military and Veterans.

If you are in the Armed Forces, we may disclose health information about you to appropriate military command authorities for activities they deem necessary to carry out their military mission. We may also release health information about foreign military personnel to the appropriate foreign military authority.

k. Inmates and Correctional Institutions.

If you are an inmate, or if you are detained by a law enforcement officer, we may disclose your health information to the prison officers or law enforcement officers. This may happen if it is necessary to provide you

with health care, or to maintain safety, security, and good order at the place where you are confined. This includes sharing information that is necessary to protect the health and safety of other inmates or persons involved in supervising or transporting inmates.

7. Workers' Compensation.

We may disclose your health information for workers' compensation or similar programs that provide benefits for work-related injuries.

8. Coroners, Medical Examiners, and Funeral Directors.

In the unfortunate event of your death, we may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also release this information to funeral directors as necessary to carry out their duties.



9. Organ and Tissue Donation.

In the unfortunate event of your death, we may disclose your health information to organizations that procure or store organs, eyes, or other tissues so that these organizations may investigate whether donation or transplantation is possible under applicable laws.

SPECIAL PROTECTIONS FOR CERTAIN TYPES OF INFORMATION

Some kinds of information are considered so sensitive that state or federal laws provide special protections for them. That means that we may have to get your written authorization to disclose (and sometimes to use) these types of information for treatment, payment or health care operations. We may also be required to obtain your written authorization before we can use or disclose these types of information to the government, to law enforcement officers, to courts, to researchers, and to others in the ways that we have explained above in this Notice. The following types of information are subject to special protections under state or federal law:

- Information about genetic testing or the results of genetic testing
- Information about HIV testing or test results
- Information about substance abuse rehabilitation treatment
- Information about mental health treatment or status
- Information contained in certain confidential psychotherapy notes

Your written authorization will generally be required before we may disclose these types of information. However, some exceptions apply. For example, your written authorization is not required for your therapist to use psychotherapy notes to treat you, or to disclose them to others in the course of training programs, for legal defense in an action you bring, for oversight of the therapist by an authorized government agency, or as otherwise required by law. *If you have questions about the ways that these types of information can be used or disclosed, please contact the Privacy Officer at 877-360-7626, or speak with your doctor, counselor, social worker or therapist.*

YOUR RIGHTS TO ACCESS AND CONTROL YOUR HEALTH INFORMATION

We want you to know that you have the following rights to access and control your health information. These rights are important because they will help you make sure that the health information we have about you is accurate. They may also help you control the way we use your information and share it with others, or the way we communicate with you about your medical matters. To exercise these rights, please submit your requests to each of the School of Medicine locations, including the Faculty Group Practices, that you would like to consider your request.

- 1. Your Right To Inspect and Obtain Copies of Your Records.** You have the right to inspect and obtain a copy of any of your health information that may be used to make decisions about you and your treatment for as long as we maintain this information in our records. This includes medical and billing records.

a. How to Make Your Request.

To inspect or obtain a copy of your health information, please submit your request in writing to your doctor's office. To make a request at more than one doctor's office within the School of Medicine, please submit your request directly to each office.

b. Cost.

If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies we use to fulfill your request.



c. Response Time.

We will respond to your request for inspection of records within 10 days. We ordinarily will respond to requests for copies within 30 days if the information is located in our facility and within 60 days if it is located off-site at another facility. If we need additional time to respond to a request for copies, we will notify you in writing within the time frame above to explain the reason for the delay and when you can expect to have a final answer to your request.

d. If Your Request is Denied.

Under certain very limited circumstances, we may deny your request to inspect or obtain a copy of your information. If we do, we will provide you with a summary of the information instead. We will also provide a written notice that explains our reasons for providing only a summary and a complete description of your rights to have that decision reviewed and how you can exercise those rights. The notice will also include information on how to file a complaint about these issues with us or with the Secretary of the Department of Health and Human Services. If we have reason to deny only part of your request, we will provide complete access to the remaining parts after excluding the information we cannot let you inspect or copy.

2. Your Right To Amend Records. If you believe that the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept in our records.

a. How to Make Your Request.

To request an amendment, please write to the Practice Manager of your doctor's office. Your request should include the reasons why you think we should make the amendment. To make a request at more than one doctor's office within the School of Medicine, please submit your request directly to each office.

b. Response Time.

Ordinarily we will respond to your request within 60 days. If we need additional time to respond, we will notify you in writing within 60 days to explain the reason for the delay and when you can expect to have a final answer to your request.

c. If Your Request is Denied.

If we deny a part of or your entire request, we will provide a written notice that explains our reasons for doing so. You will have the right to have certain information related to your requested amendment included in your records. For example, if you disagree with our decision, you will have an opportunity to submit a statement explaining your disagreement, which we will include in your records. We will also include information on how to file a complaint with us or with the Secretary of the United States Department of Health and Human Services. These procedures will be explained in more detail in any written denial notice we send you.

3. Your Right To An Accounting Of Disclosures. After April 14, 2003, you have a right to request an "accounting of disclosures." This report identifies certain other persons or organizations to whom we have disclosed your health information. ***The accounting does***

not include routine disclosures made for treatment, payment and operations or pursuant to a patient authorization. It also does not include certain other disclosures set forth in Section 3.d. below.

a. How to Make Your Request.

To request an accounting of disclosures, please write directly to your doctor's office. Your request must state a time period within the past six years (but after April 14, 2003) for the disclosures you want us to include. For example, you

may request a list of the disclosures that we made between January 1, 2004 and January 1, 2005. To make a request at more than one doctor's office within the School of Medicine, please submit your request directly to each office.



b. Cost.

You have a right to receive one accounting within every 12-month period for free. However, we may charge you for the cost of providing any additional accounting in that same 12-month period. We will always notify you of any cost involved so that you may choose to withdraw or modify your request before any costs are incurred.

c. Response Time.

Ordinarily we will respond to your request for an accounting within 60 days. If we need additional time to prepare the accounting you have requested, we will notify you in writing about the reason for the delay and the date when you can expect to receive the accounting. In rare cases, we may have to delay providing you with the accounting without notifying you because a law enforcement official or government agency has asked us to do so.

d. What is Not Included in the Accounting of Disclosures?

An accounting of disclosures does not describe every instance in which your health information has been shared.

Specifically, an accounting of disclosures does not include information about the following disclosures:

- Disclosures we made to you or your personal representative;
- Disclosures we made pursuant to your written authorization;
- Disclosures we made for treatment, payment or business operations;
- Disclosures made to your friends and family involved in your care or payment for your care;
- Disclosures that were incidental to permissible uses and disclosures of your health information (for example, when information is overheard by another patient passing by);
- Disclosures for purposes of research, public health, or our business operations of limited portions of your health information that do not directly identify you;
- Disclosures made to federal officials for national security and intelligence activities;
- Disclosures about inmates to correctional institutions or law enforcement officers; and
- Disclosures made before April 14, 2003.

4. Your Right To Request Additional Privacy Protections You have the right to request that we further restrict the way we use and disclose your health information to treat your condition, collect payment for that treatment, or run our business operations. You may also request that we limit how we disclose information about you to family or friends involved in your care. For example, you could request that we not disclose information about a surgery you had.

a. How to Make Your Request.

To request restrictions, please write to your doctor's office. Your request should include (1) what information you want to limit; (2) whether you want to limit how we use the information, how we share it with others, or both; and (3) to whom you want the limits to apply. To make a request at more than one doctor's office within the School of Medicine, please submit your request directly to each office.

b. We are Not Required to Agree.

We are not required to agree to your request for a restriction, and in some cases the restriction you request may not be permitted under law. However, if we do agree, we will be bound by our agreement unless the information is needed to provide you with emergency treatment or comply with the law. Once we have agreed to a restriction, you have the right to revoke the restriction at any time. Under some circumstances, we will also have the right to revoke the restriction as long as we notify you before doing so; in other cases, we will need your permission before we can revoke the restriction.



5. Your Right To Request Alternative Communications. You have the right to request that we communicate with you

about your medical matters in a more confidential way by requesting that we communicate with you by alternative means or at alternative locations. For example, you may ask that we contact you at home instead of at work.

How to Make Your Request.

To request alternative communications, please write directly to your doctor's office. *We will not ask you the reason for your request, and we will try to accommodate all reasonable requests.* Please specify in your request how or where you wish to be contacted, and how payment for your health care will be handled if we communicate with you through this alternative method or location. To make a request at more than one doctor's office within the School of Medicine, please submit your request directly to each office.



E-Mail Consent Form

Purpose: This form is used to obtain your consent to communicate with you by email regarding your protected health information (PHI).

NYU Urology Associates offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail has a number of risks that patients should consider before granting consent to use e-mail for these purposes.

NYU Urology Associates will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, NYU Urology Associates cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information.

Patient's Acknowledgment and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of e-mail between NYU Urology Associates and me and consent to the conditions outlined herein. Any questions I may have had were answered. I agree and consent that NYU Urology Associates may communicate with me regarding my protected health information by e-mail.

Patient signature: _____

Date: _____

Patient Name: _____

Patient Address: _____

Patient E-mail Address: _____