COLUMBIA UNIVERSITY
MEDICAL CENTER

Discover. Educate. Care. Lead.

Registration Form

For Office Use Only:
MRN Number: ______________________ **Dx:** ______________

Name: ______________________

Street Address: ______________________

City: ______________ **State:** ________ **Zip Code:** ________

Home Phone Number: ______________ **Daytime Number:** ______________

Cell Phone: ______________ **Email Address:** ______________

Date of Birth (mm/dd/yyyy): ______________ **S.S#:** ______________

Sex: Male/Female **Marital Status: Single Married Separated Divorced Widowed**

Father's First Name: ______________ **Mother's First Name:** ______________

Employer: ______________ **Occupation:** ______________

Employer's Address ______________ **City, State, Zip Code:** ______________

Physician Information

Referring Physician: ______________
Office Phone Number: ______________
Office Fax Number: ______________
Address: ______________
City, State, Zip Code: ______________

Primary Care Physician: ______________
Office Phone Number: ______________
Office Fax Number: ______________
Address: ______________
City, State, Zip Code: ______________

Pharmacy Information

Pharmacy Name: ______________
Pharmacy Phone: ______________
Pharmacy Fax Number: ______________
Address: ______________
City, State, Zip Code: ______________

RX Benefit Plan: ______________
____
____
____

Insurance Information

Primary Insurance

Insurance Company: ______________________
Name of Policy Holder: ______________________
Group Number: ______________ Policy Number: ______________
Address: ______________ City, State, Zip Code: ______________

Secondary Insurance

Insurance Company: ______________________
Name of Policy Holder: ______________________
Group Number: ______________ Policy Number: ______________
Address: ______________ City, State, Zip Code: ______________

I, the undersigned, certify that I (or my dependent) have insurance coverage with ______________ and assign directly to Dr.__________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment or benefits; I authorize the use of this signature on all insurance submissions

______________ ______________ ______________

Responsible Party Signature ***Relationship*** ***Date***

ColumbiaDoctors

Patient Payment Policy

Patient Name:______________________________ **MRN #**__________________ **Date:**_______________

Thank you for choosing the Department of __________________ at Columbia University Medical Center. We understand that many patients find insurance coverage and financial responsibility issues complex and confusing so we have outlined our practice's policy. If you have any questions about our policies, our staff will be happy to assist you.

What Is My Financial Responsibility?

Your financial responsibility depends on a variety of factors, explained below.

Payment for Office Visits and Services

(1) If You Have...	(2) You Are Responsible For...	(3) We Will...
Managed Care or Commercial Indemity insurance plan and the provider is not a participating provider or benefits are considered out-of-network.	Paying 100% of the provider's full charges.	Submit an insurance claim to your insurance carrier on your behalf.
Managed care plan and the physician is a participating provider or benefits are considered in-network	Obtaining referral authorization, if applicable Paying your deductible, copayments and any other financial obligation as stated in your plan	Inform you of any services not covered by your plan. Submit an insurance claim to your insurance carrier
Traditional Medicare	Paying your deductible if it is not yet met for the calendar year, as well as any services not covered by Medicare. If you do not have secondary coverage or Medigap, you will also be asked to pay the 20% Medicare coinsurance.	Submit the Medicare claim, as well as any claims to your secondary insurance. For services that may not be covered by Medicare provide you with a Medicare ABN or Waiver for signature.
Traditional Medicaid	Area Specific: Generally, you are responsible for no payment when the physician's office accepts Medicaid. If Medicaid is not accepted, you may be responsible for the visit charge upfront.	If Medicaid is accepted in your physician's office, we will bill Medicaid. If Medicaid is not accepted, we will collect the visit charge upfront.
Worker's Compensation or No Fault	Providing to our staff a valid case number, accident date, insurance name and address, adjuster name and phone number. Providing authorization for the service if needed. Providing an AOB form for your No Fault carrier. No payment is due at the time of service.	Call your carrier ahead of time to verify the accident date, claim number, primary care physician, employer information, and referral procedures.
Uninsured	Paying 100% of the provider's full charges	Work with you to settle your account.

Patients Who Are Minors

A parent or legal guardian must accompany patients who are minors on the patient's first visit. This accompanying adult is responsible for payment of the account, according to the policy outlined on the previous pages, or must provide complete and accurate information about the guarantor on the insurance that will be billed.

Agreement Confirmation

I have read, understand, and agree to this Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayment and deductible are my responsibility and are payable immediately upon receipt of patient statement.
I authorize my insurance benefits be paid directly to ______________________________________.
I authorize the Department of __________________ at Columbia University Medical Center to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

____________________________ ____________________________ ____________

Patient or Guarantor Printed Name *Patient or Guarantor Signature* *Date*

ColumbiaDoctors
The Physicians and Surgeons of Columbia University

NewYork-Presbyterian
The University Hospital of Columbia and Cornell

Division of Colon & Rectal Surgery
Medical History

Today's Date: ______________________

Name: ______________________

Date of Birth: ______________________

Current Medications

Medication Name	Dosage	How Often

NewYork-Presbyterian
The University Hospital of Columbia and Cornell

50705

Department of Perioperative Services
Preoperative Medical Questionnaire - Assessment Data Form

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

GENERAL PATIENT INFORMATION: (To be completed by Patient, Guardian or Admitting Nurses)

Name: ____________________

Fluent in English: ☐ Yes ☐ No Preferred Language Spoken: ____________ Translator needed: ☐ Yes ☐ No

Age: ________ Sex: ________ Date of Birth: ____/____/____

Surgeon Name: ____________ Expected Date of Surgery ____/____/____

Primary Care Physician: ____________

Primary Care Physician's Phone No. (______) ____________

Cardiologists Name ____________ Phone No.: (______) ____________

Expected Procedure: ____________

Home Phone: (______) ________ Work Phone: (______) ________ Cell Phone: (______) ________

Telephone Number to be Reached Prior to Surgery: ____________

Best time to call: ☐ Afternoon ☐ Evening May we leave a message? ☐ Yes ☐ No

Do you have allergies? ☐ Yes ☐ No ☐ FOOD ☐ DRUG ☐ LATEX ☐ OTHER ________

ALLERGEN	REACTION

LIST PRIOR SURGERY	DATE	LIST ANY COMPLICATIONS
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	

What previous Anesthesia have you had?
☐ General ☐ Regional ☐ Spinal ☐ Epidural ☐ Local ☐ None ☐ Unsure

Please list any complications/problems experienced with anesthesia.

____

____

____

Please list prior Hospitalizations including Emergency Department visits

____

____

____

50705 (9/11)

NewYork-Presbyterian
The University Hospital of Columbia and Cornell

Department of Perioperative Services
Preoperative Medical Questionnaire - Assessment Data Form

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

	PATIENT ONLY		CLINICIAN USE ONLY	
	No	Yes	Test for "Yes" Answers	Anesthesia Consult *
Heart: Do you have or ever had the following:				
1) Atrial fibrillation or irregular heartbeat?			EKG	*
2) High blood pressure or Mitral Valve Prolapse?			EKG	
3) A heart attack, angina, or chest pain?			CBC, EKG	*
4) A heart murmur, heart failure or heart surgery?			CBC, EKG	*
5) High cholesterol?				
6) Chest pain or shortness of breath when climbing a flight of stairs?			EKG	*
7) A catheterization of your heart? If so, ... Date ___/___/___ Where ______			CBC, EKG	*
8) A heart stress test? If so, ... Date ___/___/___ Where ______			CBC, EKG	
Do you: 9) Take antibiotics prior to a surgical procedure or dental work?				
10) Do you have a pacemaker or implantable defibrillator (AICD)? If yes, manufacturer: (check one) ☐ Medtronic ☐ Guidant ☐ St. Jude ☐ Biotronik ☐ Other Date ___/___/___ Where ______ *Ask your cardiologist to send the most recent pacemaker interrogation to the surgeon and please bring your information card with you on the day of surgery.*			If yes, contact EP specialist	
11) Are you 60 years old or older?			EKG	
Breathing: Do you have or ever had the following:				
12) Shortness of breath with exertion or swollen ankles?			CBC, EKG	*
13) A need for more than one pillow or wake up at night short of breath?			CBC, EKG	
14) Tuberculosis (TB)?			CXR	
15) Smoked more than 1 pk/day for 20 yrs or 2 pks/day for 10 yrs?			CBC, CXR	
16) Smoked in the last year?				
17) Oxygen at home to help you breathe?			CBC, CXR	*
18) Severe emphysema, asthma or bronchitis (COPD) that limits your activities?			EKG, CXR	*
19) Did you ever have an embolus or clot go to your lung?				
Obstructive Sleep Apnea (OSA):				
20) Do you have Obstructive Sleep Apnea (OSA)?			CBC, EKG, CXR	*
21) Do you frequently snore loudly, enough to be heard through closed doors?			CBC, EKG	
22) Have you been told by others that you gasp, choke, snort, or stop breathing during your sleep?			CBC, EKG	*
23) Do you have or are you being treated for high blood pressure?			EKG	
24) Do you use a BIPAP or C-PAP machine at home? If so, settings: ______			CBC, CXR	*

* Anesthesia Consult Recommended
CBC = CBC plus platelets, BMP = BUN, CL, CO2, CRE, Gluc, K, NA, AnionGAP,
LIV = ALB, ALP, ALT, AST, DBIL, TBIL, TP

NewYork-Presbyterian
The University Hospital of Columbia and Cornell

50705

Department of Perioperative Services
Preoperative Medical Questionnaire - Assessment Data Form

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

	PATIENT ONLY		CLINICIAN USE ONLY	
Blood Disorders: Do you have or ever had the following:	No	Yes	Test for "Yes" Answers	Anesthesia Consult *
25) Anemia or low blood count?			CBC	
26) Bleeding ulcers or rectal bleeding?			CBC	
27) Sickle cell disease or trait?			CBC, CXR	
28) Blood clots in your legs (phlebitis) or Deep Vein Thrombosis (DVT)?				
Do you:				
29) Use warfarin (Coumadin) as a blood thinner?			PT/INR	*
30) Bruise easily and/or have a bleeding problem?			CBC, PT/INR/APTT	
Endocrine/Renal Disorders: Do you have or ever had the following:				
31) Diabetes?			BMP, EKG	
32) Adrenal or thyroid disease or tumor?			BMP	
33) Kidney disease, kidney failure or are you on dialysis?			BMP, EKG, CBC	
34) Severe hepatitis, jaundice, cirrhosis or liver failure?			LIV, PT, INR, APPT	
35) Do you use diuretics (water pills), digoxin (Lanoxin) or steroids (Prednisone)?			BMP, EKG	
Gastrointestinal: Do you have or ever had the following:				
36) Severe abdominal pain?				
37) Loss of appetite or unintentional weight loss in the past year?				
38) Acid reflux?				
Neurological/Musculo/Skeletal: Do you have or ever had the following:				
39) Stroke or seizures?			BMP, EKG, CBC	
40) Weakness in your arms or legs?				
41) Head, neck or back injuries?				
42) Chronic pain?				
43) "Pins and needles" or loss of sensation in your arms or legs?				
44) "Collagen disease", Lupus, Rheumatoid arthritis, or Raynaud's disease?				
Obstetrics				
45) Are you or do you believe you might be pregnant? Last menstrual cycle ______			BHCG	
46) Have you been pregnant in the last 3 months?			If yes to (#45 & #46) a blood specimen must be sent < 72 hours of surgery for T & S and T & C	
Cancer: Do you have or ever had the following:				
47) Cancer and/or received chemotherapy?			CBC	
48) Have you received radiation therapy?			CXR, EKG, CBC	
49) An axillary lymph node dissection (under arm): ☐ Yes ☐ No. Which side: ______				

* Anesthesia Consult Recommended
CBC = CBC plus platelets, BMP = BUN, CL, CO2, CRE, Gluc, K, NA, AnionGAP,
LIV = ALB, ALP, ALT, AST, DBIL, TBIL, TP

NewYork-Presbyterian
The University Hospital of Columbia and Cornell

Department of Perioperative Services
Preoperative Medical Questionnaire - Assessment Data Form

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

	PATIENT ONLY		CLINICIAN USE ONLY	
Anesthesia Related Issues: Have you had:	No	Yes	Test for "Yes" Answers	Anesthesia Consult *
50) Problems with placement of a breathing tube in your windpipe (trachea) for surgery?				*
51) Surgery on your throat, vocal cords or lungs?				*
52) Any bad reactions to anesthesia in you or your relatives?				*
53) A history of Malignant Hyperthermia in you or any of your relatives?				*
54) Do you have trouble opening your mouth or bending your neck forward or backward?				*
55) Are you having Bariatric (weight loss), Vascular or Thoracic Surgery (chest)?				*
You will see YOUR anesthesiologist on the day of surgery. In addition, 56) Do you want to see a screening Anesthesiologist before the day of Surgery?				*
Communicable Disease: Do you have or ever had the following:				
57) ☐ HERPES ☐ AIDS ☐ HIV				
58) Contact within the last month with anyone suspected of having SARS?				
59) Have you traveled outside of the U.S. in the last month? If yes, where? ______				
Eyes: Do you have or had the following:				
60) Dry eyes?				
61) Glaucoma or cataracts?				
Behavioral Health				
62) Have you suffered from anxiety, depression, or a psychiatric disorder?				
Blood Transfusion: Do you have or had the following:				
63) Blood transfusion in the last 3 months?			If yes to (#63) a blood specimen must be sent < 72 hours prior to surgery for T&S and T&C	
64) A reaction or allergy to a blood transfusion?				
65) Did you donate blood for this surgery?				
66) Did a family member donate blood?				

* Anesthesia Consult Recommended
CBC = CBC plus platelets, BMP = BUN, CL, CO2, CRE, Gluc, K, NA, AnionGAP,
LIV = ALB, ALP, ALT, AST, DBIL, TBIL, TP

Patient/Guardian Signature ______________________ Date: ___/___/_____ Time: ________ AM/PM

If completed by the RN: ______________________ RN Date: ___/___/_____ Time: ________ AM/PM
Nurses Signature

COLUMBIA UNIVERSITY
MEDICAL CENTER

Health Insurance Portability and Accountability Act (HIPAA)
HIPAA Compliance/Columbia University Medical Center
601 West 168th Street, Apt. #22, 2nd Floor
New York, NY 10032/ T(212) 342-0059 F(212)342-5173
http://www.cumc.columbia.edu/hipaa/

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

DATE:__________________

I acknowledge that I was provided with a copy of the Columbia University Medical Center Notice of Privacy Practices.

____________________________ ____________________________
Patient Name (Print) Patient Signature

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

____________________________ ____________________________
Personal Representative (Print) Personal Representative's Signature

____
Relationship

For Columbia University Medical Center use only.

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

I have made a good faith effort to obtain a written acknowledgement of receipt of Columbia University Medical Center's Notice of Privacy Practices but was unable to for the following reason:

- ☐ Patient refused to sign
- ☐ Patient unable to sign
- ☐ Other ______________

____________________________ ____________________________
Employee Name Date

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

Revised October 2007

ColumbiaDoctors

Authorization to Release Medical Information

Patient Name: ______________________________ Date of Birth: ________________

Address: ______________________________ Phone: ________________

City: ______________ State: ______ Zip: ______

I authorize the release of the following protected health information:

□ Office Notes /Name of Physician ____

□ Pathology Reports □ Radiology Reports □ Laboratory Reports Date(s): ___________

□ Other:________________ □ Paper Copy □ Electronic Copy

The purpose for this request to release medical information is:

□ Medical Care / Treatment □ Insurance □ Other (specify)________________

Send my medical information to: Name: ______________________________________

Address: ______________________________________

City, State, Zip: ______________________________________

I understand that:

- By signing this form, I am authorizing the use or disclosure of protected health information as indicated above.
- I may refuse to sign this authorization, which will not affect my treatment or payment for health care.
- I may revoke this authorization at any time before the information I have requested is released by providing written notice of revocation as specified in the Notice of Privacy Practices.
- If the receiving party is not subject to medical records privacy laws, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law. Columbia University Medical Center shall not be held liable for any consequences resulting from re-disclosure
- If the information to be released contains any information about HIV/AIDS an additional HIPAA release of medical information for will be requested.
- Alcohol or substance abuse, mental health or psychiatry notes may have additional compliance requirements that must be met before the information can be released.
- A copy of this signed form will be provided to me.
- CUMC may charge an administrative fee to cover the cost of labor, copying, and postage. The physician's office will inform me of any charges and arrange for payment.
- This Authorization expires on ___/___/___ {if date not completed / one year after signed}

______________________________ ______________________

Patient / Representative Signature **Date**

If the patient listed above is a minor or is unable to sign and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

______________________________ ______________________________

Print Name **Relationship to patient**

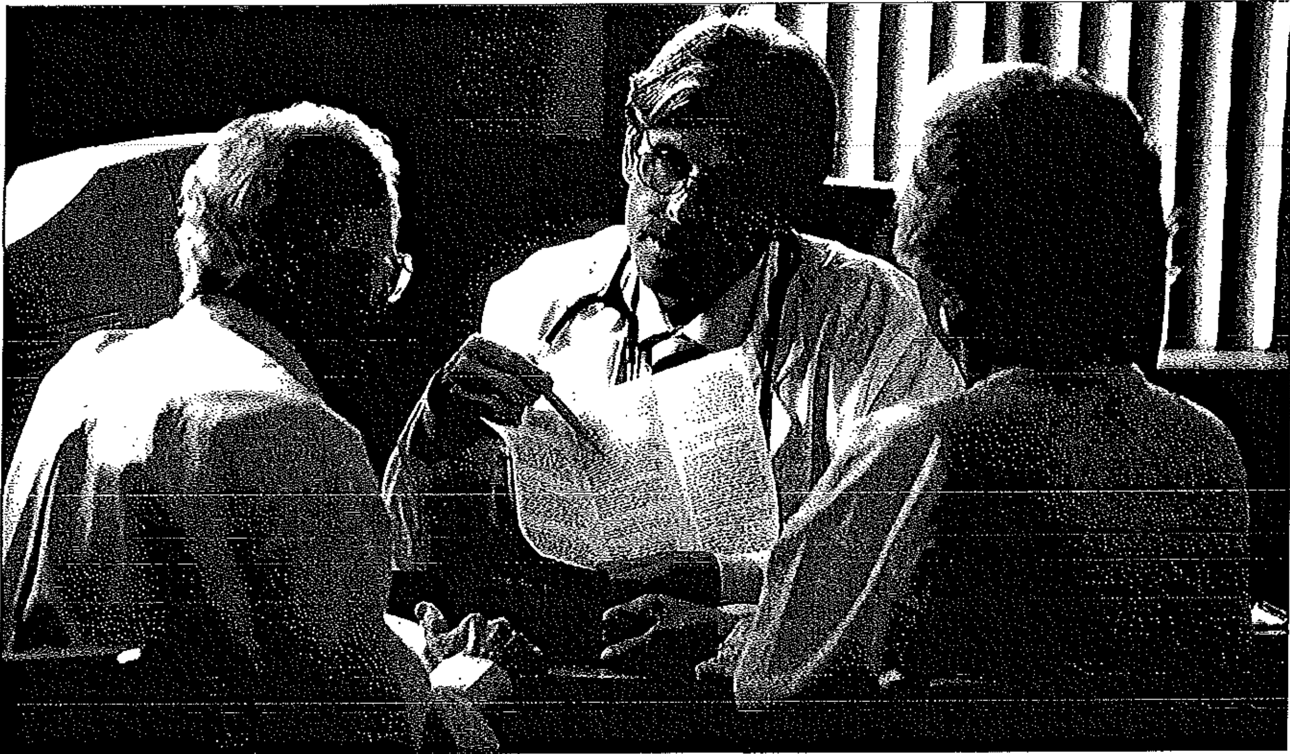
Retain this form in the patient's medical record and provide a copy to the patient.

An additional authorization (NYS DOH-2557) is required for disclosures when your medical records contain information relating to Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV) including but not limited to test results and the fact that the test was taken.

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.

COLUMBIA UNIVERSITY
MEDICAL CENTER



About this notice

This Notice will tell you about the ways we may use and disclose health information that identifies you ("Health Information"). We also describe your rights and certain obligations we have regarding the use and disclosure of Health Information. We are required by law to maintain the privacy of Health Information that identifies you; give you this Notice of our legal duties and privacy practices with respect to your Health Information; and follow the terms of our Notice that are currently in effect. This Notice covers the faculty physician practices of Columbia University Medical Center ("Columbia University", "Columbia", "we" or "us"), including its employed faculty physicians and faculty physicians practicing on Columbia University owned or leased space, as well as their clinical support staff. This Notice also covers Columbia University Health Care, Inc.; the Ophthalmology Faculty Practice Corporation; Orthopedics, P.C.; Neurosurgery, P.C.; and Urology, P.C. (all "Columbia University"). If Columbia physicians or health care professionals provide you with treatment or services at another location, for example New York Presbyterian Hospital, the Notice of Privacy Practices you receive at such other location will apply.

How we may use and disclose health information about you

The following categories describe different ways that we may use and disclose Health Information.

For Treatment

We may use Health Information about you to provide you with medical treatment or services. We may disclose Health Information to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you. For example, a doctor treating you for a broken leg may need to know if you have diabetes, because diabetes may slow the healing process. Different departments of Columbia University also may share Health Information such as prescriptions, lab work and x-rays to coordinate your treatment. We also may disclose Health Information to people outside Columbia University who may be involved in your medical care.

For Payment

We may use and disclose Health Information so that we may bill for treatment and services you receive at Columbia University and can collect payment from you, an insurance company or another third party. For example, we may need

Patient Copy

to give your health plan information about your treatment in order for your health plan to pay for such treatment. We also may tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. In the event a bill is overdue we may need to give Health Information to a collection agency as necessary to help collect the bill or may disclose an outstanding debt to credit reporting agencies.

For Health Care Operations

We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and for our operation and management purposes. For example, we may use Health Information to review the treatment and services you receive to check on the performance of our staff in caring for you. We also may disclose information to doctors, nurses, technicians, medical students, and other personnel for educational and learning purposes. The entities and individuals covered by this Notice also may share information with each other for purposes of our joint health care operations.

Appointment Reminders/Treatment Alternatives/ Health-Related Benefits and Services

We may use and disclose Health Information to contact you to remind you that you have an appointment for treatment or medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

Fundraising Activities

We may use your demographic information to contact you in an effort to raise money for Columbia. Any fundraising letter you receive from us will provide you with instructions on how to opt out of any future fundraising letters. We will not use your diagnosis to fundraise unless you authorize us to do so in writing.

Individuals Involved in Your Care or Payment for Your Care

We may release Health Information to a person who is involved in your medical care or helps pay for your care, such as a family member or friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research

Under certain circumstances, we may use and disclose Health Information for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. Before we use or disclose Health Information for research, however, the project will go through a special approval process. This process evaluates a proposed research project and its use of Health Information to balance the benefits of research with the need for privacy of Health Information. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for similar purposes, so long as they do not remove or take a copy of any Health Information.

As Required by Law

We will disclose medical information about you when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety

We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, will be to someone who may be able to help prevent the threat.

Business Associates

We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to

perform billing services on our behalf. All of our business associates are obligated, under contract with us, to protect the privacy of your Information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation

If you are an organ or tissue donor, we may release Health Information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary, to facilitate organ or tissue donation and transplantation.

Military and Veterans

If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation

We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks

We may disclose Health Information for public health activities. These activities generally include disclosures to: a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence and the patient agrees or we are required or authorized by law to make such disclosure.

Health Oversight Activities

We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement

We may release Health Information if asked by a law enforcement official for the following reasons: in response to a court order, subpoena, warrant, summons or similar process; limited information to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; about a death we believe may be the result of criminal conduct; about criminal conduct on our premises; and in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

National Security and Intelligence Activities and Protective Services

We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law. We also may disclose Health Information to authorized federal officials so they may conduct special investigations and provide protection to the President, other authorized persons and foreign heads of state.

Coroners, Medical Examiners and Funeral Directors

We may release Health Information to a coroner, medical examiner or funeral director so that they can carry out their duties.

Inmates

If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

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 information, mental health information, and genetic information. Some parts of this general Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact the Privacy Officer for more information about the protections.

Other Uses of Health Information

Other uses and disclosures of Health Information not covered by this Notice or the laws that apply to us will be made only with your written permission. You may revoke your permission at any time by submitting a written request to our Privacy Officer, except to the extent that we acted in reliance on your permission.

Your Rights Regarding Health Information About You

You have the following rights, subject to certain limitations, regarding Health Information we maintain about you:

Right to Inspect and Copy

You have the right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. We may charge you a fee for the costs of copying, mailing or other supplies associated with your request.

Right to Request Amendments

If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information and you must tell us the reason for your request. You have the right to request an amendment for as long as the information is kept by or for Columbia. A request for amendments must be submitted, in writing, to the Privacy Officer at the address provided at the end of this notice.

Right to an Accounting of Disclosures

You have the right to request an "accounting of disclosures" of Health Information. This is a list of certain disclosures we made of Health Information. The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list.

Right to Request Restrictions

You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we agree, we will comply with your request unless we terminate our agreement or the information is needed to provide you with emergency treatment.

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time. You may obtain a copy of this Notice at our web site, **http://www.cumc.columbia.edu/hipaa/.**

How to Exercise Your Rights

To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the end of this Notice. Alternatively, to exercise your right to inspect and copy Health Information, you may contact your physician's office directly. To obtain a paper copy of our Notice, contact our Privacy Officer by phone or mail.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for Health Information we already have as well as any information we receive in the future. We will post a copy of the current Notice at each Columbia physician office or outpatient location and on our website. The end of our Notice will contain the Notice's effective date.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with Columbia or with the Secretary of the Department of Health and Human Services. To file a complaint with Columbia, contact our Privacy Officer at the address listed at the end of this notice. You will not be penalized for filing a complaint.

COLUMBIA UNIVERSITY MEDICAL CENTER

Questions

If you have a question about this Privacy Notice, please contact:

Privacy Officer
Office for HIPAA Compliance

Columbia University Medical Center
601 West 168th Street
Apartment 22
New York, NY 10032
Phone: 212-305-7315
E-mail: hipaa@columbia.edu
Website: www.cumc.columbia.edu/hipaa

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