

Notice of Privacy Practices of VIP Community Services, Inc (VIP)

Adopted: 2008

Revised 2011, 2015, 2018, 6/25/2021, 4/8/2024, 3/20/2025, 3/2026

This notice describes:

- **HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED**
- **YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION**
- **HOW TO FILE A COMPLAINT CONCERNING A VIOLATION OF THE PRIVACY OR SECURITY OF YOUR HEALTH INFORMATION, OR OF YOUR RIGHTS CONCERNING YOUR INFORMATION.**

PLEASE REVIEW IT CAREFULLY. You have a right to a copy of this Notice (in paper or electronic form) and to discuss this Notice with VIP's Compliance/Privacy Officer, Tabitha Gaffney. Please contact Tabitha Gaffney, at (718) 583-5150, at ext. 8210 or tgaffney@vipservices.org if you have any questions.

This notice applies to VIP Community Services, Inc and our workforce members (employees, contractors, volunteers, etc.) and to the health information that we create and maintain about you.

General Information:

This Notice of Privacy Practices describes how VIP Community Services. ("VIP") and its professional staff may use and disclose your protected health information to conduct treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care treatments and services.

According to federal law and regulations, and New York State law, VIP is required to maintain the privacy of your protected health information.

- Your comprehensive record includes your medical and billing record created by VIP, any approved amendments to your medical record and any external records received from external providers that VIP used to make decisions about your treatment.
- We will let you know promptly if a breach comprises the privacy or security of your information.
- We will not use or share your information from your record, including any Part 2 Records, other than described in this Notice unless you consent in writing. You may change your mind at any time. To revoke your consent, submit a request in writing to the Compliance/Privacy Officer, Tabitha Gaffney at 718-583-5150 x 8210 or tgaffney@vipservices.org. If you revoke your consent, it will not affect any information we shared based on your earlier permission.

Provision of the Notice of Privacy Practices

We provide you with this Notice to inform you of our legal duties and privacy practices with respect to your protected health information. You have a right to receive this Notice whether you are receiving services delivered in person, electronically or through remote technology. We are required to follow the terms of this Notice of Privacy Practices. We may change the terms of our Notice at any time. The new Notice will cover protected health information that we maintain at that time. If we revise this Notice of Privacy Practices, we will

post the new Notice throughout VIP, and if you request a copy of the revised Notice, we will provide a copy to you.

HIPAA regulations, 45 CFR § 164.520 (c) (1) require that VIP provide the Notice no later than the date of the first service delivery, including at the time of admission or intake. VIP will make a good faith effort to obtain the patient's written acknowledgement of receipt of the Notice. When written acknowledgement can't be obtained, staff will document the effort made and the reason acknowledgement was not obtained. VIP must also have copies of the Notice available onsite for patients, on request, to take, and posted in a location where patients can easily read it. Whenever there is a material change to the notice, the notice must be promptly revised, made available upon request, and re-posted.

Substance Use Privacy regulations; 42 CFR Part 2 (Part 2) requires that VIP provide the Notice at the time of admission or as soon thereafter as the patient is capable of communication (**42 C.F.R. §2.22(a)**). The Rule requires that the substance use treatment program must provide the Notice to a patient on the date services are first delivered, including delivered electronically, after April 14, 2003. In emergency treatment situations, this Notice must be provided as soon as reasonably practical after the emergency treatment situation..

Electronic Delivery

VIP may provide this Notice to you electronically, including through email or electronic means, if you agree to receive the Notice electronically. You may withdraw your agreement at any time, and if VIP learns that you didn't receive the electronic document, VIP will provide a paper copy of the Notice. You have the right to request a paper copy even if you previously agreed to receive it electronically.

When first service delivery to an individual is provided over the Internet, through e-mail, or otherwise electronically, the provider must send an electronic notice automatically and contemporaneously in response to the individual's first request for service. The provider must make a good faith effort to obtain a return receipt or other transmission from the individual in response to receiving the Notice.

The program must also have copies of the Notice available on site for patients, on request, to take, and posted in a location where patients can easily read it. Whenever there is a material change to the notice, the notice must be promptly revised, made available upon request, and re-posted. A covered entity must prominently post and make available its Notice on its website that provides information about its customer services or benefits.

New York State Law: State laws allow minors to consent to certain health care services without parental or legal guardian consent. These services include certain mental health services, substance use treatment, and sexual reproductive health. The record related to these services are confidential and may only be disclosed with the minor's written authorization or as permitted or required by law.

A. Uses and Disclosures of Protected Health Information

We can use or disclose protected health information for purposes of treatment, payment, and health care operations. The following examples are offered to show the types of uses and disclosures of your protected health care information that VIP is permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office with your consent.

1. **Treatment:** VIP will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care within VIP's programs and with a third party (other health care providers, pharmacies, etc.) for purposes of providing you care.

VIP maintains a Uniform Reporting System, which is a computer application that contains information regarding demographic information, medical information including HIV/AIDS status, substance abuse information and other treatment information. VIP uses the Uniform Reporting System to coordinate treatment of its clients throughout the agency. Your protected health information will be stored on the Uniform Reporting System and will only be used by VIP's staff members who are authorized to use it for your treatment. If you have any questions regarding the Uniform Reporting System, please contact VIP's Privacy Officer.

For Part 2 Records:

- You must sign a consent form allowing us to share Part 2 records, unless an exception applies. For example, if your prescription history includes medication prescribed or dispensed by our Part 2 programs, you must sign a consent form for us to share your prescription history with the hospital where you are having surgery.
 - You may sign a single consent form for all future uses and disclosures of your Part 2 records for treatment, payment and health care operations purposes.
 - In case of an emergency, we may share Part 2 records if:
 - We can't obtain your consent
 - If a state or federal authority declares a temporary state of emergency because of a natural disaster and our Part 2 program are closed and unable to provide services or obtain your consent
2. **Payment:** Your protected health information will be used, as needed, to obtain payment for your health care treatment and services. This may include certain activities that Medicaid or other government sponsored health insurance may undertake before it approves or pays for the health care treatment services we recommend for you such as, deciding eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Part 2 Records:

You must sign a consent form allowing us to share your Part 2 records for payment purposes, unless an exception applies. You may sign a single consent form for all future uses and disclosures of your Part 2 Records for payment purposes.

3. **Healthcare Operations:** We may use or disclose, as needed, your protected health information to support VIP's business activities. These activities include, but are not limited to, quality assessment, staff review, training of counselors, licensing, and conducting or arranging for other business activities. Business activities may include:
- Using a sign-in sheet at the registration desk.
 - Calling you by name in the waiting room.

Part 2 Records:

You must sign a consent form allowing us to share your Part 2 Records for operations purposes. You may sign a single consent form for all future uses and disclosures of your Part 2 Records for health care operations purposes.

4. **Single Consent to Use and Disclose Part 2 Records:**
- If you sign a single consent form allowing us to use and share your Part 2 Records for all future treatment, payment and health care operations purposes with a recipient not covered by HIPAA, the recipient may further disclose your Part 2 Records only if such action is consistent with the consent, must comply with the original consent restrictions, and cannot further redisclose without a new, explicit consent form stating such and signed by you.

- If you sign a single consent form allowing us to use and share your Part 2 Records for all future treatment, payment and health care operations with an entity subject to HIPAA regulation, also known as a covered entity (such as another health care provider) or their business associate (such as a vendor), the recipient may share your Part 2 Records as permitted by HIPAA, except for uses or sharing for civil, criminal, administrative, and legislative proceedings against you.

5. **Substance Use Disorder (SUD) Records We Receive From Other Organizations:**

If we receive SUD treatment records from another program subject to 42 CFR Part 2 and are notified the records are protected by Part 2, we will not use or disclose such records in civil, criminal, administrative, or legislative proceedings against you unless based on a written consent signed by you, or a court order after notice and an opportunity to be heard is provided to you and/or the holder of the record, as applicable, as provided in 42 CFR Part 2. A court order authorizing use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before we will use or disclose the requested record.

6. **Business Associates:** VIP will share your protected health information with third party “business associates” that perform various activities (e.g., billing, transcription services). Whenever an arrangement between VIP and a business associate involves the use or disclosure of your protected health information, will be there a prior written contract with that business associate containing terms to protect the privacy of your protected health information. Examples of business associates include:
- Independent practice associations or IPAs
 - a regional health information exchange (RHIO) which allows a secure flow of data amongst providers
 - a web-based application known as PSYCKES supporting clinical decision making, care coordination, and quality improvement under the New York Office of Mental Health
7. **Emails:** VIP may communicate using email However, VIP will not send you unsecured emails with your health information without your prior authorization. If you do authorize communications via unsecured email, you have the right to revoke the authorization at any time.

B. Uses and Disclosures of Protected Health Information Based upon Your Written

Authorization

- Other uses and disclosures of your protected health information not described in this Notice, will be made only with your written authorization, unless otherwise permitted or required by law.
- You may revoke this authorization, at any time, in writing, except to the extent that VIP may have already acted in reliance on your authorization.
- Your substance use records, or testimony relaying the content of such records, will not be used or disclosed in any civil administrative, criminal, or legislative proceedings against you, unless, based on your written consent or a court order.
- Your substance use records will only be used or disclosed based on a court order after notice and an opportunity for you or the holder of the record to be heard is provided.
- Your substance records that are disclosed to a Part 2 program, another provider required to follow HIPAA regulations, or a business associate based on your written consent for treatment, payment, and health care operations may be further disclosed by that Part 2 program, provider, or business associate, without your written consent, to the extent the HIPAA regulations permit.

C. Permitted and Required Uses and Disclosures That May Be Made Without Your

Consent, Authorization or Opportunity to Object¹

1. **Others Involved in Your Healthcare:** Unless you object, we may disclose to persons you have identified in the VIP acknowledgement form, such as a member of your family, a relative or a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care or the payment of your care.
2. **Emergencies:** We may use or disclose your protected health information in an emergency treatment situation. If this happens, a VIP staff member will try to obtain your consent as soon as possible after the delivery of treatment. If a VIP staff member is required by law to treat you and the VIP staff member has attempted unsuccessfully to get your consent, he or she may still use or disclose your protected health information to treat you if it is determined that it is in your best interest based on our professional judgment.
3. **Communication Barriers:** VIP may use and disclose your protected health information for interpretation purposes, if a VIP staff member has attempted to obtain consent from you but is unable to because of substantial communication barriers. VIP will reasonably conclude that you have chosen to be assisted by the interpreter, from your willingness to continue the encounter using the interpreter, and reasonably infers that you do not object to VIP's use or disclosure of your health information under the circumstances.
4. **Required or Permitted by Law:** VIP may use or disclose your protected health information to the extent that the law requires the use or disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.
5. **Public Health:** VIP may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability or preventing death.

For Part 2 Records: Using or sharing Part 2 Records for public health purposes requires a written consent except:

- For public health purposes, we can disclose the records without consent if the disclosure is made to a public health authority and information from the Part 2 record has been de-identified
- If medical personnel from the Food and drug Administration (FDA) assert a reason to believe that your health may be threatened by an error in the manufacture, labeling, or sale of a product under FDA jurisdiction, we may disclose Part 2 Records for the exclusive purpose of notifying you or your physician.
- We are mandated reporters and must report suspected child abuse and neglect to appropriate state and local authorities, as required by law.
- We can share certain information from your Part 2 Records with law enforcement if a crime is committed or threatened on the premises of our Part 2 program(s) or against Part 2 program staff members. Information released will be limited to the circumstances of the incident, including the patient status of the individual committing or threatening to commit the crime, that individual's name and address, and that individual's last known whereabouts.

¹ This section refers to medical records that do not include psychotherapy notes, as described in Section B, above.

6. **Communicable Diseases:** VIP may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
7. **Health Oversight:** VIP may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.
8. **Abuse or Neglect:** VIP may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect.
9. **Food and Drug Administration:** VIP may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, or product deviations; to track products; to enable product recalls; to make repairs or replacements; or to conduct post-marketing surveillance, as required.
10. **Legal Proceedings:** VIP, as a drug and alcohol treatment, is required to comply with the federal regulations as stated in 42 C.F.R. Part 2. VIP will only disclose your Part 2 health information in response to a court or administrative order, or in response to a subpoena if it is accompanied by a court order.

For Part 2 records:

- Part 2 records or testimony relaying the content of such records, will not be used or disclosed in any civil, administrative, criminal, or legislative proceedings against you unless based on specific written consent signed by you or a court order
 - Part 2 Records will only be used or disclosed based on a court order after notice and an opportunity to be heard is provided to you or to the holder of the record, where required by law
 - A court order authorizing use or disclosure must be accompanied by a subpoena or other similar legal mandate compelling disclosure before the Part 2 Record is used or disclosed
11. **Law Enforcement:** VIP may also disclose protected health information, only if applicable legal requirements are met, to allow law enforcement to investigate a crime that has occurred on VIP's premises or against VIP staff members. All other disclosures to law enforcement require a court order.
 12. **Coroners, Funeral Directors, and Organ Donation:** VIP may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. VIP may also disclose protected health information to a funeral director, as authorized by law, to permit the funeral director to conduct his/her duties. Protected health information may be used and disclosed for organ, eye, or tissue donation purposes.
 13. **Military Activity and National Security:** When the appropriate conditions apply, VIP may use or disclose protected health information of individuals who are serving in the Armed Forces for activities deemed necessary by appropriate military command authorities. VIP may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities.
 14. **Workers' Compensation:** Your protected health information may be disclosed by VIP as authorized by law to comply with workers' compensation laws and other similar legally- established programs.
 15. **Serious Threats:** Your protected health information may be used or disclosed by VIP if, in good faith, VIP believes that the use and disclosure is necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public and the disclosure is made to a person(s) reasonably able to prevent or lessen the threat.

16. **Research:** We can use or share information from your health record, including any Part 2 Records, for health research, in accordance with HIPAA and 42 CFR Part 2.

17. Required Uses and Disclosures: Under the law, VIP must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

17. **Uses and Disclosures Not Described in This Notice:** VIP will make uses and disclosures not described in this Notice only with your written consent.

D. Your Rights

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

1. **You have the right to inspect and copy your protected health information.** This means you may inspect and obtain a copy of protected health information about you that VIP possesses for the past six years. The records may contain medical and billing records and any other records that VIP uses for making decisions about you.

The fastest way to get an electronic copy of the information in your record is by logging into the patient portal. You can request to access the patient portal by speaking to the receptionist at the program and provide them your email address so it can be added to your account or going to VIP's patient portal

website to sign up: https://mycw24.eclinicalweb.com/portal2043/jsp/100mp/login_otp.jsp

The following information from your record is available in the portal:

- Current medications
- Demographics: Personal and additional information
- Reset their patient portal password
- Review an active payment plan
- Secure messages from/to provider/clinician and patient
- Visit summary and progress note
- Dental treatment plan
- Referrals
- Immunization history
- Labs and diagnostic imaging results
- Scanned documents
- Upcoming appointments
- Questionnaires
- Pair and track health monitors like blood pressure machines, fitness trackers, etc.
- Review/download health education materials

State law limits the circumstances under which we may provide a parent or legal guardian with access to certain health information of minors. Currently, minors and their parents or legal guardians are unable to access the minor's records through the portal. To request access to records, minors and their authorized representatives must contact their program or VIP's Privacy Officer.

You can also request an electronic or paper copy of your record. You can make the written request to your program or VIP's Compliance Department.

VIP has the right to charge you the cost of copying your medical and billing files. Under federal law, you have a right to inspect or copy the PHI in your medical record except:

- a. Psychotherapy notes (HIPAA regulations-45 CFR § 164.524 (a) (1) (i): created by a health care provider who is a mental health professional documenting /analyzing the contents of conversation during a private counseling session or a group and that are separated from the medical record.
- b. SUD counseling notes- 42 CFR § 2.31 (b): created by a counselor, therapist, or clinician that document contents of a private session with a SUD patient
- c. Information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding.
- d. Protected health information that is subject to a law that prohibits access to it.
- e. PHI from an entity other than VIP obtained under a promise of confidentiality when the access requested would be likely to reveal the source of the information.

We may deny a request for access to PHI under certain circumstances. You have the right to request an appeal in accordance with the requirements of the applicable law.

2. **You have the right to request a restriction on the use and disclosure of your protected health information including your Part 2 records at any time.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations at any time.

- You may revoke any previously granted consent for the use of your Part 2 records at any time.
- You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices.
- You have the right to request and obtain a restriction to disclose your records to your health plan for services that you paid for in full.
- Your request, which must be in writing, must state the specific restriction requested and to whom you want the restriction to apply.
- VIP is not required to agree to a restriction that you request, except if you request that your protected health information not be disclosed to a payor and you agree to pay out of pocket, VIP must comply. If VIP agrees to the requested restriction, VIP may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency medical treatment and services.
- You may request a restriction by contacting VIP's Privacy Officer and specifying in writing what restriction you wish to place on VIP's use of your protected health information.

3. **You have the right to request confidential communications from VIPus by alternative means or at an alternative location.** VIP will accommodate reasonable requests. VIP may also condition this accommodation by asking you for information as to how payment will be handled or for specification of the alternative address or other method of contact. VIP will not request an explanation from on the reason for the request. Please make this request is in writing to VIP's Privacy Officer.

4. **You have the right to request to have VIP amend your protected health information.** This means you may request an amendment of your protected health information in VIP's possession for as long as we maintain this information. In certain cases, we may deny your request for an amendment if, for example, the record was not created by VIP, or the record is deemed complete and accurate. If your request to amend was denied, you have the right to file a statement of disagreement with us. VIP may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal. Any such statement of disagreement or rebuttal will become part of your health information file. You must make your request in writing.

5. **You have the right to receive an accounting of certain disclosures (including electronic disclosures) VIP has made of your protected health information.** You may request an accounting for a specific

timeframe but for no greater than six years prior to the date of the request. If you are in a Part 2 program, you have a right to a list of disclosures made by any persons who received your records under a general designation based on your written consent and will disclose your records to other providers on your treatment team, for the past three years. The right to receive this information is subject to certain exceptions, restrictions, and limitations.

6. **If you are enrolled in a Part 2 program, you have a right to provide a single consent for all future uses or disclosures for treatment, payment, and health care operations purposes.** This means you may complete one consent form giving VIP permission to use or disclose your PHI for the purpose of treatment, payment, and health care operations for the duration of your enrollment without getting consent each time.
7. **You have the right to receive a notification if there is a breach of your PHI.** Generally, upon the discovery of a breach of unsecured protected health information, VIP must notify everyone whose unsecured information has been or is reasonably believed to have been accessed, acquired, used, or disclosed because of such breach.
8. **You have a right to elect not to receive fundraising communications.** To opt out, contact the Privacy Officer, Tabitha Gaffney at 718-583-5150 x 8210.
9. **You have a right to get a copy of this Notice.** You can ask for a paper copy even if you have agreed to receive this Notice electronically. We will provide you with a copy promptly.
10. **You have a right to choose someone to act for you.** If you have given someone medical power of attorney or you have a legal guardian, that person can exercise your rights and make choices about your record including your Part 2 record.

E. Complaints/Questions

You may file a complaint at VIP by notifying VIP's Compliance/Privacy Officer, of your complaint. You may contact our Compliance/Privacy Officer at (718) 583-5150, ext. 8210 or visit at 770 East 176th Street, Bronx, NY 10460 **OR**;

Contact the Office for Civil Rights at:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
Phone: 202-619-0257
Toll Free: 1-877-696-6775
OCR Hotline-Voice: 800-368-1019
www.hhs.gov/ocr/privacy/hipaa/complaints

VIP will not retaliate against you for filing a complaint and will continue to treat you.

PATIENT'S BILL OF RIGHTS

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

- (1) Receive services(s) without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation, or source of payment.
- (2) Be treated with consideration, respect, and dignity, including privacy in treatment.
- (3) Be informed of services available at the center.
- (4) Be informed of the provision for off-hour emergency coverage.
- (5) Be informed of charges for services, eligibility for third-party reimbursements, and, when applicable, the availability of free or reduced-cost care.
- (6) Receive an itemized copy of his/her account statement upon request.
- (7) Obtain from his/her health care practitioner, or the health care practitioner delegate, complete and current information concerning his/her diagnosis, treatment, and prognosis in terms that the patient can be reasonably expected to understand.
- (8) Receive all the information 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.
- (9) Refuse treatment to the extent permitted by law and to be fully informed of the medical consequences of his/her action.
- (10) Refuse to participate in experimental research.
- (11) Voice grievances and recommend changes in policies and services to the Health Service's staff, the operator, and the New York State Department of Health without fear of reprisal.
- (12) Express complaints about the care and services provided and have the agency investigate such complaints. The agency is responsible for providing the patient or his/her designee with a written response within 30 days if requested by the patient, indicating the findings of the investigation. The agency is also responsible for notifying the patient of his/her designee that if the patient is not satisfied with the agency's response, the patient may complain to the New York Department of Health Office of Primary Health System Management.
- (13) Privacy and Confidentiality of all information and reports pertaining to the treatment.
- (14) Approve or refuse the release record or disclosure of the contents of his/her medical records to any healthcare practitioner and/or healthcare facility except as required by law or third-party payment contract
- (15) Access his/her medical record pursuant to the provision of section 18 of the Public Health Law and Subpart 50-3 of this Title:
- (16) Authorize those family members and other adults who will be given priority to visit, consistent with your ability to receive visitors.
- (17) When applicable, make known your wishes regarding anatomical gifts. You may document your wishes in your healthcare Proxy. 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 health care proxy, will, donor card, or other signed paper). The health care proxy is available from the center.
- (18) View a list of the health plans and the hospitals that the center participates in; and
- (19) Receive an estimate of the amount that you will be billed after services are rendered

If you think that your rights have not been observed, or if you have another sort of problem with Health Services, the grievance procedure is as follows:

1. Discuss the issue with the Clinical Director.
2. If the Clinical Director cannot resolve it immediately, you can request to speak/meet with the Chief Clinical Officer.
3. If you still find no resolution, you may request a meeting with the Chief Operating Officer.
4. If you still believe your complaint has not been addressed, you can speak/meet with the Chief Compliance Officer.
5. If all the steps above do not result in a resolution or at any time in the process, you can contact:
 - o New York State Department of Health (NYS DOH), To file a complaint call: 800-804-5447
 - o New York State Justice Center for the Protection of People with Special Needs, 161 Delaware Ave., Delmar, New York 12054
 - o Call Vulnerable Person's Central Register (VPCR) at 855-373-2122
 - o New York State Department of Health: 212-417-4200

Current VIP Staff:

Sr. VP & Chief Clinical Officer Darcia Bryden-Currie, 718-583-5150: Ext 8270

Assistant VP of Health Services: Anna Otero, 718-583-5150: Ext 8833

Executive VP and Chief Operating Officer: Opal Dunstan, 718-583-5150: Ext 8980

Sr. VP & Chief Compliance Officer: Tabitha Gaffney, 718-583-5150: Ext 8210

HEALTH CARE PROXY

Appointing Your Health Care Agent in New York State

The New York Health Care Proxy Law allows you to appoint someone you trust — for example, a family member or close friend — to make health care decisions for you if you lose the ability to make decisions yourself. By appointing a health care agent, you can make sure that health care providers follow your wishes. Your agent can also decide how your wishes apply as your medical condition changes. Hospitals, doctors and other health care providers must follow your agent's decisions as if they were your own. You may give the person you select as your health care agent as little or as much authority as you want. You may allow your agent to make all health care decisions or only certain ones. You may also give your agent instructions that he or she has to follow. This form can also be used to document your wishes or instructions with regard to organ, eye and/or tissue donation.

About the Health Care Proxy Form

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

1. This form gives the person you choose as your agent the authority to make all health care decisions for you, including the decision to remove or provide life-sustaining treatment, unless you say otherwise in this form. "Health care" means any treatment, service or procedure to diagnose or treat your physical or mental condition.
2. Unless your agent reasonably knows your wishes about artificial nutrition and hydration (nourishment and water provided by a feeding tube or intravenous line), he or she will not be allowed to refuse or consent to those measures for you.
3. Your agent will start making decisions for you when your doctor determines that you are not able to make health care decisions for yourself.
4. You may write on this form examples of the types of treatments that you would not desire and/or those treatments that you want to make sure you receive. The instructions may be used to limit the decision-making power of the agent. Your agent must follow your instructions when making decisions for you.
5. You do not need a lawyer to fill out this form.
6. You may choose any adult (18 years of age or older), including a family member or close friend, to be your agent. If you select a doctor as your agent, he or she will have to choose between acting as your agent or as your attending doctor because a doctor cannot do both at the same time. Also, if you are a patient or resident of a hospital, nursing home or mental hygiene facility, there are special restrictions about naming someone who works for that facility as your agent. Ask staff at the facility to explain those restrictions.
7. Before appointing someone as your health care agent, discuss it with him or her to make sure that he or she is willing to act as your agent. Tell the person you choose that he or she will be your health care agent. Discuss your health care wishes and this form with your agent. Be sure to give him or her a signed copy. Your agent cannot be sued for health care decisions made in good faith.
8. If you have named your spouse as your health care agent and you later become divorced or legally separated, your former spouse can no longer be your agent by law, unless you state otherwise. If you would like your former spouse to remain your agent, you may note this on your current form and date it or complete a new form naming your former spouse.
9. Even though you have signed this form, you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped if you object, nor will your agent have any power to object.
10. You may cancel the authority given to your agent by telling him or her or your health care provider orally or in writing.
11. Appointing a health care agent is voluntary. No one can require you to appoint one.
12. You may express your wishes or instructions regarding organ, eye and/or tissue donation on this form.

Frequently Asked Questions

Why should I choose a health care agent?

If you become unable, even temporarily, to make health care decisions, someone else must decide for you. Health care providers often look to family members for guidance. Family members may express what they think your wishes are related to a particular treatment. Appointing an agent lets you control your medical treatment by:

- allowing your agent to make health care decisions on your behalf as you would want them decided;
- choosing one person to make health care decisions because you think that person would make the best decisions;
- choosing one person to avoid conflict or confusion among family members and/or significant others.

You may also appoint an alternate agent to take over if your first choice cannot make decisions for you.

Who can be a health care agent?

Anyone 18 years of age or older can be a health care agent. The person you are appointing as your agent or your alternate agent cannot sign as a witness on your Health Care Proxy form.

How do I appoint a health care agent?

All competent adults, 18 years of age or older, can appoint a health care agent by signing a form called a Health Care Proxy. You don't need a lawyer or a notary, just two adult witnesses. Your agent cannot sign as a witness. You can use the form printed here, but you don't have to use this form.

When would my health care agent begin to make health care decisions for me?

Your health care agent would begin to make health care decisions after your doctor decides that you are not able to make your own health care decisions. As long as you are able to make health care decisions for yourself, you will have the right to do so.

What decisions can my health care agent make?

Unless you limit your health care agent's authority, your agent will be able to make any health care decision that you could have made if you were able to decide for yourself. Your agent can agree that you should receive treatment, choose among different treatments and decide that treatments should not be provided, in accordance with your wishes and interests. However, your agent can only make decisions about artificial nutrition and hydration (nourishment and water provided by feeding tube or intravenous line) if he or she knows your wishes from what you have said or what you have written. The Health Care Proxy form does not give your agent the power to make non-health care decisions for you, such as financial decisions.

Why do I need to appoint a health care agent if I'm young and healthy?

Appointing a health care agent is a good idea even though you are not elderly or terminally ill. A health care agent can act on your behalf if you become even temporarily unable to make your own health care decisions (such as might occur if you are under general anesthesia or have become comatose because of an accident). When you again become able to make your own health care decisions, your health care agent will no longer be authorized to act.

How will my health care agent make decisions?

Your agent must follow your wishes, as well as your moral and religious beliefs. You may write instructions on your Health Care Proxy form or simply discuss them with your agent.

Frequently Asked Questions, *continued*

How will my health care agent know my wishes?

Having an open and frank discussion about your wishes with your health care agent will put him or her in a better position to serve your interests. If your agent does not know your wishes or beliefs, your agent is legally required to act in your best interest. Because this is a major responsibility for the person you appoint as your health care agent, you should have a discussion with the person about what types of treatments you would or would not want under different types of circumstances, such as:

- whether you would want life support initiated/continued/removed if you are in a permanent coma;
- whether you would want treatments initiated/continued/removed if you have a terminal illness;
- whether you would want artificial nutrition and hydration initiated/withheld or continued or withdrawn and under what types of circumstances.

Can my health care agent overrule my wishes or prior treatment instructions?

No. Your agent is obligated to make decisions based on your wishes. If you clearly expressed particular wishes, or gave particular treatment instructions, your agent has a duty to follow those wishes or instructions unless he or she has a good faith basis for believing that your wishes changed or do not apply to the circumstances.

Who will pay attention to my agent?

All hospitals, nursing homes, doctors and other health care providers are legally required to provide your health care agent with the same information that would be provided to you and to honor the decisions by your agent as if they were made by you. If a hospital or nursing home objects to some treatment options (such as removing certain treatment) they must tell you or your agent BEFORE or upon admission, if reasonably possible.

What if my health care agent is not available when decisions must be made?

You may appoint an alternate agent to decide for you if your health care agent is unavailable, unable or unwilling to act when decisions must be made. Otherwise, health care providers will make health care decisions for you that follow instructions you gave while you were still able to do so. Any instructions that you write on your Health Care Proxy form will guide health care providers under these circumstances.

What if I change my mind?

It is easy to cancel your Health Care Proxy, to change the person you have chosen as your health care agent or to change any instructions or limitations you have included on the form. Simply fill out a new form. In addition, you may indicate that your Health Care Proxy expires on a specified date or if certain events occur. Otherwise, the Health Care Proxy will be valid indefinitely. If you choose your spouse as your health care agent or as your alternate, and you get divorced or legally separated, the appointment is automatically cancelled. However, if you would like your former spouse to remain your agent, you may note this on your current form and date it or complete a new form naming your former spouse.

Can my health care agent be legally liable for decisions made on my behalf?

No. Your health care agent will not be liable for health care decisions made in good faith on your behalf. Also, he or she cannot be held liable for costs of your care, just because he or she is your agent.

Frequently Asked Questions, *continued*

Is a Health Care Proxy the same as a living will?

No. A living will is a document that provides specific instructions about health care decisions. You may put such instructions on your Health Care Proxy form. The Health Care Proxy allows you to choose someone you trust to make health care decisions on your behalf. Unlike a living will, a Health Care Proxy does not require that you decide in advance decisions that may arise. Instead, your health care agent can interpret your wishes as medical circumstances change and can make decisions you could not have known would have to be made.

Where should I keep my Health Care Proxy form after it is signed?

Give a copy to your agent, your doctor, your attorney and any other family members or close friends you want. Keep a copy in your wallet or purse or with other important papers, but not in a location where no one can access it, like a safe deposit box. Bring a copy if you are admitted to the hospital, even for minor surgery, or if you undergo outpatient surgery.

May I use the Health Care Proxy form to express my wishes about organ, eye and/or tissue donation?

Yes. Use the optional organ, eye and/or tissue donation section on the Health Care Proxy form and be sure to have the section witnessed by two people. You may specify that your organs, eyes and/or tissues be used for transplantation, research or educational purposes. Any limitation(s) associated with your wishes should be noted in this section of the proxy. **Failure to include your wishes and instructions on your Health Care Proxy form will not be taken to mean that you do not want to be an organ, eye and/or tissue donor.**

Can my health care agent make decisions for me about organ, eye and/or tissue donation?

Yes. As of August 26, 2009, your health care agent is authorized to make decisions after your death, but only those regarding organ, eye and/or tissue donation. Your health care agent must make such decisions as noted on your Health Care Proxy form.

Who can consent to a donation if I choose not to state my wishes at this time?

It is important to note your wishes about organ, eye and/or tissue donation to your health care agent, or “health care proxy,” family members, and the person responsible for disposition of your remains. If you have not already made your wishes to become, or not to become, an organ and/or tissue donor known, New York Law provides a list of individuals who are authorized to consent to organ, eye and/or tissue donation on your behalf. They are listed as follows, in order of priority: your health care agent/proxy; your spouse, if you are not legally separated, or your domestic partner; a son or daughter 18 years of age or older; either of your parents; a brother or sister 18 years of age or older; an adult grandchild; a grandparent; a guardian appointed for you by a court prior to your death; or any other person authorized to dispose of your body.

HEALTH CARE PROXY FORM INSTRUCTIONS

Item (1)

Write the name, home address and telephone number of the person you are selecting as your agent.

Item (2)

If you want to appoint an alternate agent, write the name, home address and telephone number of the person you are selecting as your alternate agent.

Item (3)

Your Health Care Proxy will remain valid indefinitely unless you set an expiration date or condition for its expiration. This section is optional and should be filled in only if you want your Health Care Proxy to expire.

Item (4)

If you have special instructions for your agent, write them here. Also, if you wish to limit your agent's authority in any way, you may say so here or discuss them with your health care agent. If you do not state any limitations, your agent will be allowed to make all health care decisions that you could have made, including the decision to consent to or refuse life-sustaining treatment.

If you want to give your agent broad authority, you may do so right on the form. Simply write: I have discussed my wishes with my health care agent and alternate and they know my wishes including those about artificial nutrition and hydration.

If you wish to make more specific instructions, you could say:

If I become terminally ill, I do/don't want to receive the following types of treatments....

If I am in a coma or have little conscious understanding, with no hope of recovery, then I do/don't want the following types of treatments:....

If I have brain damage or a brain disease that makes me unable to recognize people or speak and there is no hope that my condition will improve, I do/don't want the following types of treatments:....

I have discussed with my agent my wishes about _____ and I want my agent to make all decisions about these measures.

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

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

Item (5)

You must date and sign this Health Care Proxy form. If you are unable to sign yourself, you may direct someone else to sign in your presence. Be sure to include your address.

Item (6)

You may state wishes or instructions about organ, eye and /or tissue donation on this form. New York law does provide for certain individuals in order of priority to consent to an organ, eye and/or tissue donation on your behalf: your designated health care agent/proxy; your designated agent to control the disposition of your remains; your spouse, if you are not legally separated, or your domestic partner; a son or daughter 18 years of age or older; either of your parents; a brother or sister 18 years of age or older; an adult grandchild; a grandparent; a guardian appointed by a court prior to your death; or any other person authorized to dispose of your body.

Item (7)

Two witnesses 18 years of age or older must sign this Health Care Proxy form. The person who is appointed your agent or alternate agent cannot sign as a witness.

HEALTH CARE PROXY

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

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

(2) Optional: Alternate Agent

If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint _____
(name, home address and telephone number)

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. (Optional: If you want this proxy to expire, state the date or conditions here.) This proxy shall expire (specify date or conditions):

(4) **Optional:** I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. (If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.) I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions (attach additional pages as necessary):

In order for your agent to make health care decisions for you about artificial nutrition and hydration (nourishment and water provided by feeding tube and intravenous line), your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

(5) Your Identification *(please print)*

Your Name _____

Your Signature _____ Date _____

Your Address _____

(6) Optional: Organ, Eye and/or Tissue Donation

I hereby make an anatomical gift, to be effective upon my death, of:
(check any that apply)

☐ Any needed organs, eyes and/or tissues

☐ The following organs, eyes and/or tissues _____

☐ Limitations _____

If you do not state your wishes or instructions about organ, eye and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature _____ Date _____

(7) Statement by Witnesses *(Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)*

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

Witness 1

Date _____

Name *(print)* _____

Signature _____

Address _____

Witness 2

Date _____

Name *(print)* _____

Signature _____

Address _____



**Department
of Health**

HEALTH CARE PROXY

Appointing Your Health Care Agent in New York State

The New York Health Care Proxy Law allows you to appoint someone you trust — for example, a family member or close friend — to make health care decisions for you if you lose the ability to make decisions yourself. By appointing a health care agent, you can make sure that health care providers follow your wishes. Your agent can also decide how your wishes apply as your medical condition changes. Hospitals, doctors and other health care providers must follow your agent's decisions as if they were your own. You may give the person you select as your health care agent as little or as much authority as you want. You may allow your agent to make all health care decisions or only certain ones. You may also give your agent instructions that he or she has to follow. This form can also be used to document your wishes or instructions with regard to organ, eye and/or tissue donation.

About the Health Care Proxy Form

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

1. This form gives the person you choose as your agent the authority to make all health care decisions for you, including the decision to remove or provide life-sustaining treatment, unless you say otherwise in this form. "Health care" means any treatment, service or procedure to diagnose or treat your physical or mental condition.
2. Unless your agent reasonably knows your wishes about artificial nutrition and hydration (nourishment and water provided by a feeding tube or intravenous line), he or she will not be allowed to refuse or consent to those measures for you.
3. Your agent will start making decisions for you when your doctor determines that you are not able to make health care decisions for yourself.
4. You may write on this form examples of the types of treatments that you would not desire and/or those treatments that you want to make sure you receive. The instructions may be used to limit the decision-making power of the agent. Your agent must follow your instructions when making decisions for you.
5. You do not need a lawyer to fill out this form.
6. You may choose any adult (18 years of age or older), including a family member or close friend, to be your agent. If you select a doctor as your agent, he or she will have to choose between acting as your agent or as your attending doctor because a doctor cannot do both at the same time. Also, if you are a patient or resident of a hospital, nursing home or mental hygiene facility, there are special restrictions about naming someone who works for that facility as your agent. Ask staff at the facility to explain those restrictions.
7. Before appointing someone as your health care agent, discuss it with him or her to make sure that he or she is willing to act as your agent. Tell the person you choose that he or she will be your health care agent. Discuss your health care wishes and this form with your agent. Be sure to give him or her a signed copy. Your agent cannot be sued for health care decisions made in good faith.
8. If you have named your spouse as your health care agent and you later become divorced or legally separated, your former spouse can no longer be your agent by law, unless you state otherwise. If you would like your former spouse to remain your agent, you may note this on your current form and date it or complete a new form naming your former spouse.
9. Even though you have signed this form, you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped if you object, nor will your agent have any power to object.
10. You may cancel the authority given to your agent by telling him or her or your health care provider orally or in writing.
11. Appointing a health care agent is voluntary. No one can require you to appoint one.
12. You may express your wishes or instructions regarding organ, eye and/or tissue donation on this form.

Frequently Asked Questions

Why should I choose a health care agent?

If you become unable, even temporarily, to make health care decisions, someone else must decide for you. Health care providers often look to family members for guidance. Family members may express what they think your wishes are related to a particular treatment. Appointing an agent lets you control your medical treatment by:

- allowing your agent to make health care decisions on your behalf as you would want them decided;
- choosing one person to make health care decisions because you think that person would make the best decisions;
- choosing one person to avoid conflict or confusion among family members and/or significant others.

You may also appoint an alternate agent to take over if your first choice cannot make decisions for you.

Who can be a health care agent?

Anyone 18 years of age or older can be a health care agent. The person you are appointing as your agent or your alternate agent cannot sign as a witness on your Health Care Proxy form.

How do I appoint a health care agent?

All competent adults, 18 years of age or older, can appoint a health care agent by signing a form called a Health Care Proxy. You don't need a lawyer or a notary, just two adult witnesses. Your agent cannot sign as a witness. You can use the form printed here, but you don't have to use this form.

When would my health care agent begin to make health care decisions for me?

Your health care agent would begin to make health care decisions after your doctor decides that you are not able to make your own health care decisions. As long as you are able to make health care decisions for yourself, you will have the right to do so.

What decisions can my health care agent make?

Unless you limit your health care agent's authority, your agent will be able to make any health care decision that you could have made if you were able to decide for yourself. Your agent can agree that you should receive treatment, choose among different treatments and decide that treatments should not be provided, in accordance with your wishes and interests. However, your agent can only make decisions about artificial nutrition and hydration (nourishment and water provided by feeding tube or intravenous line) if he or she knows your wishes from what you have said or what you have written. The Health Care Proxy form does not give your agent the power to make non-health care decisions for you, such as financial decisions.

Why do I need to appoint a health care agent if I'm young and healthy?

Appointing a health care agent is a good idea even though you are not elderly or terminally ill. A health care agent can act on your behalf if you become even temporarily unable to make your own health care decisions (such as might occur if you are under general anesthesia or have become comatose because of an accident). When you again become able to make your own health care decisions, your health care agent will no longer be authorized to act.

How will my health care agent make decisions?

Your agent must follow your wishes, as well as your moral and religious beliefs. You may write instructions on your Health Care Proxy form or simply discuss them with your agent.

Frequently Asked Questions, *continued*

How will my health care agent know my wishes?

Having an open and frank discussion about your wishes with your health care agent will put him or her in a better position to serve your interests. If your agent does not know your wishes or beliefs, your agent is legally required to act in your best interest. Because this is a major responsibility for the person you appoint as your health care agent, you should have a discussion with the person about what types of treatments you would or would not want under different types of circumstances, such as:

- whether you would want life support initiated/continued/removed if you are in a permanent coma;
- whether you would want treatments initiated/continued/removed if you have a terminal illness;
- whether you would want artificial nutrition and hydration initiated/withheld or continued or withdrawn and under what types of circumstances.

Can my health care agent overrule my wishes or prior treatment instructions?

No. Your agent is obligated to make decisions based on your wishes. If you clearly expressed particular wishes, or gave particular treatment instructions, your agent has a duty to follow those wishes or instructions unless he or she has a good faith basis for believing that your wishes changed or do not apply to the circumstances.

Who will pay attention to my agent?

All hospitals, nursing homes, doctors and other health care providers are legally required to provide your health care agent with the same information that would be provided to you and to honor the decisions by your agent as if they were made by you. If a hospital or nursing home objects to some treatment options (such as removing certain treatment) they must tell you or your agent BEFORE or upon admission, if reasonably possible.

What if my health care agent is not available when decisions must be made?

You may appoint an alternate agent to decide for you if your health care agent is unavailable, unable or unwilling to act when decisions must be made. Otherwise, health care providers will make health care decisions for you that follow instructions you gave while you were still able to do so. Any instructions that you write on your Health Care Proxy form will guide health care providers under these circumstances.

What if I change my mind?

It is easy to cancel your Health Care Proxy, to change the person you have chosen as your health care agent or to change any instructions or limitations you have included on the form. Simply fill out a new form. In addition, you may indicate that your Health Care Proxy expires on a specified date or if certain events occur. Otherwise, the Health Care Proxy will be valid indefinitely. If you choose your spouse as your health care agent or as your alternate, and you get divorced or legally separated, the appointment is automatically cancelled. However, if you would like your former spouse to remain your agent, you may note this on your current form and date it or complete a new form naming your former spouse.

Can my health care agent be legally liable for decisions made on my behalf?

No. Your health care agent will not be liable for health care decisions made in good faith on your behalf. Also, he or she cannot be held liable for costs of your care, just because he or she is your agent.

Frequently Asked Questions, *continued*

Is a Health Care Proxy the same as a living will?

No. A living will is a document that provides specific instructions about health care decisions. You may put such instructions on your Health Care Proxy form. The Health Care Proxy allows you to choose someone you trust to make health care decisions on your behalf. Unlike a living will, a Health Care Proxy does not require that you decide in advance decisions that may arise. Instead, your health care agent can interpret your wishes as medical circumstances change and can make decisions you could not have known would have to be made.

Where should I keep my Health Care Proxy form after it is signed?

Give a copy to your agent, your doctor, your attorney and any other family members or close friends you want. Keep a copy in your wallet or purse or with other important papers, but not in a location where no one can access it, like a safe deposit box. Bring a copy if you are admitted to the hospital, even for minor surgery, or if you undergo outpatient surgery.

May I use the Health Care Proxy form to express my wishes about organ, eye and/or tissue donation?

Yes. Use the optional organ, eye and/or tissue donation section on the Health Care Proxy form and be sure to have the section witnessed by two people. You may specify that your organs, eyes and/or tissues be used for transplantation, research or educational purposes. Any limitation(s) associated with your wishes should be noted in this section of the proxy. **Failure to include your wishes and instructions on your Health Care Proxy form will not be taken to mean that you do not want to be an organ, eye and/or tissue donor.**

Can my health care agent make decisions for me about organ, eye and/or tissue donation?

Yes. As of August 26, 2009, your health care agent is authorized to make decisions after your death, but only those regarding organ, eye and/or tissue donation. Your health care agent must make such decisions as noted on your Health Care Proxy form.

Who can consent to a donation if I choose not to state my wishes at this time?

It is important to note your wishes about organ, eye and/or tissue donation to your health care agent, or “health care proxy,” family members, and the person responsible for disposition of your remains. If you have not already made your wishes to become, or not to become, an organ and/or tissue donor known, New York Law provides a list of individuals who are authorized to consent to organ, eye and/or tissue donation on your behalf. They are listed as follows, in order of priority: your health care agent/proxy; your spouse, if you are not legally separated, or your domestic partner; a son or daughter 18 years of age or older; either of your parents; a brother or sister 18 years of age or older; an adult grandchild; a grandparent; a guardian appointed for you by a court prior to your death; or any other person authorized to dispose of your body.

HEALTH CARE PROXY FORM INSTRUCTIONS

Item (1)

Write the name, home address and telephone number of the person you are selecting as your agent.

Item (2)

If you want to appoint an alternate agent, write the name, home address and telephone number of the person you are selecting as your alternate agent.

Item (3)

Your Health Care Proxy will remain valid indefinitely unless you set an expiration date or condition for its expiration. This section is optional and should be filled in only if you want your Health Care Proxy to expire.

Item (4)

If you have special instructions for your agent, write them here. Also, if you wish to limit your agent's authority in any way, you may say so here or discuss them with your health care agent. If you do not state any limitations, your agent will be allowed to make all health care decisions that you could have made, including the decision to consent to or refuse life-sustaining treatment.

If you want to give your agent broad authority, you may do so right on the form. Simply write: I have discussed my wishes with my health care agent and alternate and they know my wishes including those about artificial nutrition and hydration.

If you wish to make more specific instructions, you could say:

If I become terminally ill, I do/don't want to receive the following types of treatments....

If I am in a coma or have little conscious understanding, with no hope of recovery, then I do/don't want the following types of treatments:....

If I have brain damage or a brain disease that makes me unable to recognize people or speak and there is no hope that my condition will improve, I do/don't want the following types of treatments:....

I have discussed with my agent my wishes about _____ and I want my agent to make all decisions about these measures.

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

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

Item (5)

You must date and sign this Health Care Proxy form. If you are unable to sign yourself, you may direct someone else to sign in your presence. Be sure to include your address.

Item (6)

You may state wishes or instructions about organ, eye and /or tissue donation on this form. New York law does provide for certain individuals in order of priority to consent to an organ, eye and/or tissue donation on your behalf: your designated health care agent/proxy; your designated agent to control the disposition of your remains; your spouse, if you are not legally separated, or your domestic partner; a son or daughter 18 years of age or older; either of your parents; a brother or sister 18 years of age or older; an adult grandchild; a grandparent; a guardian appointed by a court prior to your death; or any other person authorized to dispose of your body.

Item (7)

Two witnesses 18 years of age or older must sign this Health Care Proxy form. The person who is appointed your agent or alternate agent cannot sign as a witness.

HEALTH CARE PROXY

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

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

(2) Optional: Alternate Agent

If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint _____
(name, home address and telephone number)

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. (Optional: If you want this proxy to expire, state the date or conditions here.) This proxy shall expire (specify date or conditions):

(4) **Optional:** I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. (If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.) I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions (attach additional pages as necessary):

In order for your agent to make health care decisions for you about artificial nutrition and hydration (nourishment and water provided by feeding tube and intravenous line), your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

(5) Your Identification *(please print)*

Your Name _____

Your Signature _____ Date _____

Your Address _____

(6) Optional: Organ, Eye and/or Tissue Donation

I hereby make an anatomical gift, to be effective upon my death, of:
(check any that apply)

☐ Any needed organs, eyes and/or tissues

☐ The following organs, eyes and/or tissues _____

☐ Limitations _____

If you do not state your wishes or instructions about organ, eye and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature _____ Date _____

(7) Statement by Witnesses *(Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)*

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

Witness 1

Date _____

Name *(print)* _____

Signature _____

Address _____

Witness 2

Date _____

Name *(print)* _____

Signature _____

Address _____



**Department
of Health**

Details about patient information in Bronx RHIO, Inc and the consent process:

- 1. How Your Information May be Used.** Your electronic health information will be used **only** for the following healthcare services:
 - **Treatment Services.** Provide you with medical treatment and related services, including making your information available to other health care providers that treat you, to help them make sure that you get the medical treatment you need.
 - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
 - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
 - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

NOTE: The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

- 2. What Types of Information About You Are Included.** If you give consent, VIP Community Services may access ALL of your electronic health information available through the RHIO. This includes information created before and after the date of this Consent Form. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:

Alcohol or drug use problems

Birth control and abortion (family planning)

Genetic (inherited) diseases or tests

HIV/AIDS

Mental health conditions

Sexually transmitted diseases

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

- 3. Where Health Information About You Comes From.** Information about you comes from places that have provided you with medical care or health insurance ("Information Sources"). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other ehealth organizations that exchange health information electronically. A complete list of current Information Sources is available from the Bronx RHIO, Inc. You can obtain an updated list of Information Sources at any time by checking the Bronx RHIO, Inc's website at www.bronxrhio.org or by calling 718-708-6630.

- 4. Who May Access Information About You, If You Give Consent.** Only these people may access information about you: doctors and other health care providers who serve on VIP Community Services medical staff who are involved in your medical care; health care providers who are covering or on call for VIP Community Services doctors; and staff members who carry out activities permitted by this Consent Form as described above in paragraph one. In addition, VIP Community Services may make your information available to other health care providers that treat you, to help them make sure that you get the medical treatment you need.

- 5. Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call the Bronx RHIO, Inc. at: 718-708-6630; or visit Bronx RHIO, Inc's website: www.bronxrhio.org; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: <http://www.hhs.gov/ocr/privacy/hipaa/complaints/>

- 6. Re-disclosure of Information.** Any electronic health information about you may be re-disclosed by VIP Community Services to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information. Bronx RHIO, Inc and persons who access this information through the Bronx RHIO, Inc must comply with these requirements.

- 7. Effective Period.** This Consent Form will remain in effect until the day you withdraw your consent or until such time the RHIO ceases operation or until 50 years after your death, whichever is later.

- 8. Withdrawing Your Consent.** You can change your mind at any time by completing and signing a new Consent Form and giving it to VIP Community Services. You can get this form on the Bronx RHIO, Inc's website at www.bronxrhio.org or from your provider. **Note: Organizations that access your health information through Bronx RHIO, Inc while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.**

- 9. Copy of Form.** You are entitled to get a copy of this Consent Form after you sign it.

- 10. Public Health and Organ Procurement Organization Access.** Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through the Bronx RHIO, Inc for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.