NEW YORK HOTEL TRADES COUNCIL &
HOTEL ASSOCIATION OF NEW YORK CITY, INC.
HEALTH CENTER, INC.

Medical Record No.: _____
Patient's Name: _____
Print: Last Name, First Name

GENERAL CONSENT FOR ROUTINE EXAMINATION & TREATMENT FORM – MEDICAL

Completion of this form is required for all patients seeking evaluation and treatment by the New York Hotel Trades Council & Hotel Association of New York City, Inc. – Health Center Inc. ("Health Center").

I am seeking health care and treatment for (Patient Name):_____, DOB: ___/___/____, from the Health Center and voluntarily consent to receive health care services, which may include routine medical treatment or tests for diagnosis to be provided by licensed health care practitioners and other personnel. I acknowledge that no guarantees have been made to me as to the results of treatments or examinations by the Health Center. I acknowledge that this consent includes all future appointments and care rendered, and that further consent is not necessary unless I revoke this consent in writing. I understand that this general consent applies to any routine procedure or treatment, such as administration of medication, injections, vaccines, blood drawing, laboratory testing, examination of the body, and other routine procedures.

I consent to the photographing and/or videotaping of the appropriate portions of my/the patient's body, which are pertinent to showing my/the patient's physical condition, for medical, scientific or educational purposes, provided that reasonable precautions are taken to conceal my/the patient's identity.

I authorize the Health Center to access all prescription medications that I have filled within our Health Center Pharmacies, as well as those that were filled outside of our Health Center Pharmacies, by connecting to medication history data as reported through outside Pharmacy Benefit Managers, or otherwise, for care coordination purposes.

I authorize the Health Center to access my Electronic Health Records from Mount Sinai Health System Epic Care Link (ECL) for routine and emergency care. I also consent to the Health Center sharing my Protected Health Information (PHI) with other healthcare providers through CommonWell and the Citywide Immunization Registry.

I understand that my records may include sensitive information, such as Alcohol/Drug Treatment, Psychiatric/Mental Health Treatment, Sexually Transmitted Diseases, HIV/AIDS, and/or Genetic Information. I have the right to opt out of retrieval from Mount Sinai Health System ECL or sharing through CommonWell and the Citywide Immunization Registry by providing written notice at any Funds Health Center location, via email to HIM@HotelFunds.org, or via fax to (212) 237-3008. I understand that opting out may affect the continuity of my care.

Consent Options:

- o I give consent to the Health Center's retrieval of my PHI from Mount Sinai Health System ECL.
- o I give consent to the Health Center's sharing of my PHI through CommonWell and the Citywide Immunization Registry.

The Health Center provides Telehealth services, including assessment, treatment, diagnosis, and education, using interactive audio and video communications. I confirm that I have been informed of risks, benefits and alternatives of participating in telehealth services. I understand that telehealth sessions/services shall not be recorded without my consent. I agree to receive telehealth services provided by the Health Center, utilizing HIPAA compliant telehealth technology.

I understand that I may ask questions of my/the patient's health care providers and other personnel regarding any aspect of my/the patient's diagnosis or treatments which I do not understand.

By signing below, I am indicating that I have read / (or have read to me) and fully understood the information listed above.

_____ ___/____/_____
Signature of Patient Date

Authorized Personal Representative to sign only if patient is a minor, or an adult who lacks capacity to consent on their own behalf.

_____ _____ ___/____/_____

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Signature of Authorized Personal Representative Print Last Name, First Name Date

Indicate your relationship to the patient and provide a copy of any required documentation to verify your authority to sign on behalf of the patient:

___ Parent
___ Legal Custodian (A copy of the Court Order appointing the custodian must be included in the patient's record.)
___ Legal Guardian (A copy of the Court Order appointing the guardian must be included in the patient's record.)
___ POA (A copy of the Durable Power of Attorney for Health Care Decisions must be included in the patient's record.)
___ Health Care Agent (A copy of the Health Care Proxy form must be included in the patient's record.)

WITNESS: I, _____, am an adult employee of the Health Center and I am attesting to the fact that an authorized person has signed this form.

_____ ____/_____/____
Signature of Witness Date

Questions and Complaints
If you have concerns about privacy violations or disagree with decisions regarding your medical information access, amendments, restrictions, or for confidential communication, please contact us at https://www.hotelfunds.org/contact-us/ attention Privacy Officer.

For additional information about your privacy and rights, please go to https://www.hotelfunds.org/privacy-hipaa/.

Translation Services Provided Upon Request