John Theurer Cancer Center
at Hackensack University Medical Center

HACKENSACK UNIVERSITY MEDICAL CENTER
AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use or disclosure of the named individual's health information as described below.

Patient Name	Date of Birth	Social Security Number

Address (Street, City, State, Zip Code)	Telephone Number

The following individual or organization is authorized to make the disclosure:
Hackensack University Medical Center and Regional Cancer Care Associates, LLC.

This information may be disclosed to and used by the following individual or organization:
Hackensack University Medical Center and Regional Cancer Care Associates, LLC.

Treatment dates: Past, current and future medical records as needed to provide your care

Purpose of Request: To provide you with the highest quality of care.

The following information is to be disclosed:

Discharge Summary
History & Physical Examination
Consultations (including psychiatric evaluations)
Operative Report or Procedure Reports
Emergency Department Record
Laboratory Reports (including drug screens)
Radiology or Imaging Reports
Cardiac Studies
Interdisciplinary Records (Progress Notes)
Medication Records
Nursing Notes
Physician Orders
Complete Record
Other _____

Please list all family members and friends to whom Information may be released to on the lines below:

_____

_____

_____

_____

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Expiration: Unless otherwise revoked, this authorization will expire at the end of your course of treatment.

Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and the information may not be protected by federal confidentiality rules.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, I may be denied enrollment in the research study.

I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524.

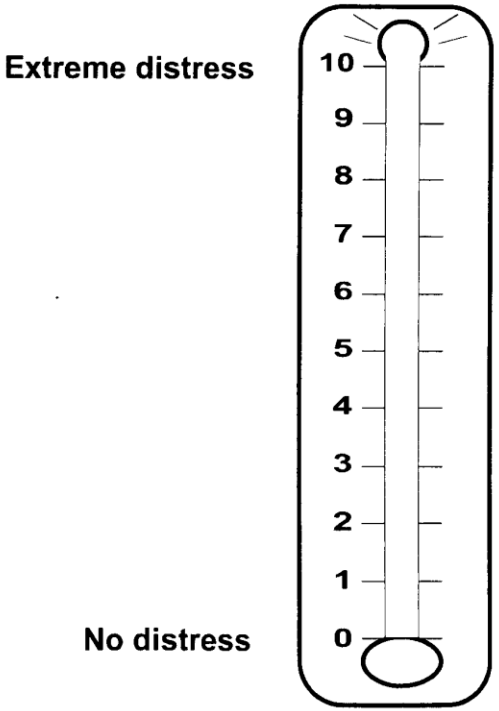
If I have any questions about disclosure of my health information, I can contact the Systems Manager in the Health Information Management Department at 201-996-2075.

Signature of Patient or Legal Representative Date

If Signed by Legal Representative, Relationship to the Patient

SCREENING TOOLS FOR MEASURING DISTRESS

Instructions: First please circle the number (0-10) that best describes how much distress you have been experiencing in the past week including today.



Second, please indicate if any of the following has been a problem for you in the past week including today. Be sure to check YES or NO for each.

YES	NO	Practical Problems
❑	❑	Child care
❑	❑	Housing
❑	❑	Insurance/financial
❑	❑	Transportation
❑	❑	Work/school
❑	❑	Treatment decisions

YES	NO	Family Problems
❑	❑	Dealing with children
❑	❑	Dealing with partner
❑	❑	Ability to have children
❑	❑	Family health issues

YES	NO	Emotional Problems
❑	❑	Depression
❑	❑	Fears
❑	❑	Nervousness
❑	❑	Sadness
❑	❑	Worry
❑	❑	Loss of interest in usual activities

YES	NO	Spiritual/religious concerns
❑	❑	

YES	NO	Physical Problems
❑	❑	Appearance
❑	❑	Bathing/dressing
❑	❑	Breathing
❑	❑	Changes in urination
❑	❑	Constipation
❑	❑	Diarrhea
❑	❑	Eating
❑	❑	Fatigue
❑	❑	Feeling Swollen
❑	❑	Fevers
❑	❑	Getting around
❑	❑	Indigestion
❑	❑	Memory/concentration
❑	❑	Mouth sores
❑	❑	Nausea
❑	❑	Nose dry/congested
❑	❑	Pain
❑	❑	Sexual
❑	❑	Skin dry/itchy
❑	❑	Sleep
❑	❑	Tingling in hands/feet

Other Problems: _____

_____

Regional Cancer Care Associates, LLC Notice of Health Information Practices

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Understanding Your Health Record/Information

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of the nation
- A source of data for facility planning and marketing
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to:

- Ensure its accuracy
- Better understand who, what, when, where, and why others may access you health information
- Make more informed decisions when authorizing disclosure to others

You're Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information as provided by Federal Regulation (45 CFR 164.522)
- Obtain a paper copy of the notice of information practices upon request
- Inspect you health record as provided for the Federal Regulation (45 CFR 164.524)
- Request an amendment to your health record as provided for in Federal Regulation (45 CFR 164.528)
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

RCCA and our medical staff are a single entity according to Federal Regulation (45 CFR 164.504). With respect to your health record that is created or maintained here we are required to:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to Information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations
- We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain.

We will not use or disclose your health information without your authorization, except as described in this notice and for treatment, payment, or health care operations.

For More Information of to Report a Problem

If you have questions and would like additional information, you may contact the Consumer Affairs Department at (201) 996-2010.

If you believe your privacy rights have been violated, you can file a complaint with the Administrative Manager of Consumer Affairs (201) 996-2010, or directly with the Secretary of health and Human Services in Washington (1-877696-6775). There will be no retaliation for filing a complaint.

Examples of Disclosures for Treatment, Payment, and Health Care Operations

We will use you health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Members of your healthcare team will record the actions they took, their observations, and their assessments. In that way, your healthcare team will know how you are responding to treatment.

We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you're discharged for this facility.

We will use your healthcare information for payment.

For example: A bill may be sent to you or a third-party payer (insurance company). The information on or accompanying the bill may include information that identifies you, as well as you diagnosis, procedures, and supplies used. We may provide copies of the applicable portions of your medical record to your insurance company in order to validate your claim.

We will use your healthcare information for regular health operations.

For example: Healthcare operations, members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: There are some services provided in our organization through contracts with business associates. Examples include: claim preparation for the physician billing in radiology, and certain laboratory tests; a copy service we use when making copies of you medical record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer (insurance company) for services rendered. To protect you health information, however, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, or you are a patient on a psychiatric unit, we will release your name, location in the facility to the general visiting public. In addition to this, your religious affiliation will be made available to the visiting clergy.

Notification: We may use or disclose information about your location and general condition to notify or assist in notifying a family member, personal representative, or another person responsible for your care.

Communication with family: Health professionals may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to their involvement in your care or payment.

Research: We may disclose information to researchers when their research has been approved by the Medical Center's Institutional Review Board (IRB). The IRB review the research proposals and established protocols to ensure the privacy for you health information.

Funeral directors and Coroners: We may disclose health information to funeral directors or coroners consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entitles engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Telephone Contact/Appointment reminders: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fund raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to extent authorized and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and safety of other individuals.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public authority or attorney, provided that a work force member or business associates believes in good faith that we have engaged in unlawful conduct or have otherwise violated professionals or clinical standards and are potentially endangering one or more patients, workers or the public.

Northern New Jersey Cancer Associates is here to protect our patients and their rights, including respecting the patient's right to privacy and confidentiality. Northern New Jersey Cancer Associates is committed to providing the highest level of care and services to all patients, while adhering to those rights.

Effective Date: April 14, 2003

I, _____, acknowledge receiving the
Patient Name

Regional Cancer Care Associates, LLC. Notice of Privacy Practices.

_____ *Date*

_____ Patient *Signature*