Jay L. Cohen, MD Dermatology

PATIENT CONSENT/OPT-IN TO THE MASSACHUSETTS HEALTH INFORMATION HIGHWAY (Mass HIway)	

The Mass HIway is a secure, statewide network that allows my healthcare providers to safely and quickly share important information about me when and where it is needed for my care (such as my allergies, medications, and health history) with the goal of improving communication among hospitals and doctors and providing better quality care to patients.

Partners HealthCare System, Inc. ("Partners HealthCare") and/or its affiliated entities and healthcare providers have provided me with information about the Mass HIway. I understand that Partners HealthCare has developed and integrated electronic medical record that is used by Partners HealthCare, it affiliated entities and healthcare providers and other non-Partners Healthcare providers such as Dana-Farber Cancer Institute, Massachusetts Eye and Ear Infirmary and certain community physicians and physician groups. I acknowledge that by signing this form below I consent to and agree that Partners HealthCare and it affiliated entities and healthcare providers and all other users of the Partners integrated electronic medical record (including but not limited to Dana-Farber Cancer Institute and Massachusetts Eye and Ear Infirmary) may request, access, send and receive my health information using the Mass HIway. I understand that the information accessed or shared using the Mass HIway may also include information created by other healthcare providers and organizations and used by Partners HealthCare and/or its affiliated entities and healthcare providers to provide care to me.

I understand that I can withdraw my consent to share my health information using the Mass HIway at any time by contacting any of the Partners HealthCare hospital privacy offices and completing the Partners HealthCare Mass HIway OPT-OUT form.

Patient Name (Print):	Date:
Patient Signature:	Date of Birth:

When the patient is a minor, or is unable to give consent, the signature of a parent, guardian, or other representative is required.	
Signature of Representative:	Date:
Print Name:	Relationship to patient:

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Jay L. Cohen, M.D., P.C.

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Jay L. Cohen, M.D., P.C. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Jay L. Cohen, M.D., P.C.'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Jay L. Cohen, M.D., P.C. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Jay L. Cohen, M.D., P.C. Privacy Officer at 464 Hillside Avenue, Suite 303, Needham MA 02494.

With my consent, Jay L. Cohen, M.D., P.C. may call my home or designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Jay L. Cohen, M.D., P.C. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Jay L. Cohen, M.D., P.C. may email to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that Jay L. Cohen, M.D., P.C. restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Jay L. Cohen, M.D., P.C.'s use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, I understand that Jay L. Cohen, M.D., P.C. may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Print Name of Patient or Legal Guardian

_____ _____

Patient's Name Date

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Patient Name: _____ DOB: _____ Today's Date: _____

Reason for your visit: _____

Are you allergic to any medications: ☐ Yes No ☐ If yes, list: _____
List all medications you are currently taking:

_____ _____
_____ _____

History of Diseases: Do you have now, or have you ever had any of the following conditions or diseases:

Bronchitis	Yes ☐ No☐	Diabetes	Yes ☐ No☐
Emphysema	Yes ☐ No☐	Thyroid	Yes ☐ No☐
Asthma	Yes ☐ No☐	Kidney	Yes ☐ No☐
Chronic cough	Yes ☐ No☐	Bladder	Yes ☐ No☐
Morning cough	Yes ☐ No☐	Stomach	Yes ☐ No☐
		Bowel	Yes ☐ No☐
High blood pressure	Yes ☐ No☐	Hepatitis or yellow skin	Yes ☐ No☐
Chest pain	Yes ☐ No☐	Glaucoma	Yes ☐ No☐
Heart attack	Yes ☐ No☐	Arthritis/joint deformity	Yes ☐ No☐
Heart murmur	Yes ☐ No☐	Convulsions, epilepsy, seizures	Yes ☐ No☐
Pacemaker	Yes ☐ No☐	Fainting	Yes ☐ No☐
Phlebitis	Yes ☐ No☐		
		Do you have artificial joint(s)?	Yes ☐ No☐
		Have you had or been exposed to HIV(AIDS)?	Yes ☐ No☐
		Have you had a reaction to dental anesthesia?	Yes ☐ No☐

Do you drink alcohol? Yes ☐ No☐ If yes, how many drinks per day? _____
Do you use IV drugs? Yes ☐ No☐ If yes, what kind, and how often? _____
Do you smoke? Yes ☐ No☐ If yes, how much? _____
Do you bleed easily? Yes ☐ No☐

Skin History:
When you are exposed to the sun do you: ☐ Tan only ☐ Tan and burn ☐ Burn
Have you ever had skin cancer? Yes ☐ No☐
Has anyone in your family had skin cancer? Yes ☐ No☐ If known, what type _____
Do you have a history of any skin diseases? Yes ☐ No☐ If yes, please list: _____

Are you pregnant? (*women only*) Yes ☐ No☐

List any other disease or condition we should know about: _____

List surgical procedures you have had in the last 6 months: _____

What is your occupation? _____

What are your hobbies? _____

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PATIENT CONSENT FOR SURESCRIPTS RELEASE OF MEDICATION HISTORY

What is Surescripts?

Surescripts connects pharmacies, care providers and benefit managers, and operates a network to allow for the movement of electronic clinical health information between different health information systems. Through the Surescripts network, authorized prescribers and pharmacies can gain access to prescription information and related information for use in providing clinical care to patients.

What is the Medication History?

The Surescripts Medication History of service allows prescribers and pharmacists to use the Surescripts network to access a patient's medication history across providers, at the point of care. This service can be used in the course of providing routine care, as well as, during emergencies. In both cases, Medication History enables health care providers to make a more informed clinical decision. To provide this service, Surescripts connects to a patient's medication history data stored in the databases of community pharmacies and pharmacy benefits managers. Surescripts then presents that data to prescribers through software for the certified vendor.

Consent

I understand that Partners HealthCare System, Inc. ("Partners HealthCare") and/or its affiliated entities has deployed integrated electronic medical record that is used by Partners HealthCare, its affiliated entities and healthcare providers and other non-Partners Healthcare providers such as Dana-Farber Cancer Institute, Massachusetts Eye and Ear Infirmary and certain community physicians and physician groups. I acknowledge that by signing this form below I consent to and agree that Partners Healthcare and its affiliated entities and healthcare providers and all other users of the Partners integrated electronic medical record (including but not limited to Dana-Farber Cancer Institute and Massachusetts Eye and Ear Infirmary) may request, access, and receive my medication history data from Surescripts.

I understand that I can withdraw my consent for Partners HealthCare and its affiliated entities and healthcare providers and all other users of the Partners integrated electronic medical record (including but not limited to Dana-Farber Cancer Institute and Massachusetts Eye and Ear Infirmary) to access my medication history data from Surescripts by contacting any of the Partners HealthCare hospital privacy offices and completing the Partners HealthCare Surescripts Opt-out form. I understand that revoking this consent will not have any effect on actions taken prior to such revocation.

_____

Patient/Personal Representative/Guardian - Please Print Name

_____ _____

Patient/Personal Representative/Guardian Signature Date

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Patient Name _____ **Date of Birth** _____ **Male or Female** _____

Address (Street, City, State, Zip) _____

Email Address: _____

Phone Numbers: Home_____ **Mobile** _____ **Work** _____

Guarantor Name _____ **Guarantor Phone Number**_____

Guarantor Address_____

Emergency Contact and Phone Number _____ **Relationship** _____

PCP Name and Phone _____

Pharmacy Name and Phone Number_____

Primary Language: _____ No Response ☐

Ethnicity: Hispanic/Latino ☐ Non-Hispanic/Latino ☐ No response☐

Race: American Indian or Alaskan Native ☐ Asian ☐ Black/African American ☐

Native Hawaiian or other Pacific Islander☐ Caucasian☐ Other ☐
No response☐

We like to offer all new patients a skin examination to screen for abnormal moles and skin cancer. This is an opportunity for us to check parts of the body, such as your back, that may be difficult for you to examine by yourself. While it is true that most skin cancers arise on areas exposed to the sun, skin cancers and abnormal moles can arise anywhere. Also, if you are here for evaluation of a rash it is helpful to have a full skin examination to enable us to more quickly and accurately diagnose your condition.

Please circle your preference:

I WOULD or WOULD NOT like to have a skin examination.

Insurance Authorization

I hereby authorize payments directly to the above-mentioned provider for services rendered in his office. I understand that I am financially responsible for any, and all charges not covered by my insurance.

Patient or Guardian Signature _____**Date:** _____