BOYS TOWN
National Research
Hospital

Dear Cochlear Implant Candidate,

Thank you for your interest in a cochlear implant evaluation at Boys Town National Research Hospital. As part of the candidacy process, our team first reviews previous test results, medical history and the completed cochlear implant adult questionnaire. After you have reviewed and completed the materials, please send the enclosed questionnaire, the releases of information, and other documentation listed below to the cochlear implant office at the address included at the bottom of this letter. If you have any questions about the paperwork, please contact Terri Wolf, patient coordinator, directly at 531-355-5698.

The following information is requested:

1. **Adult Questionnaire**
   Questionnaire to be completed by the person inquiring about the cochlear implant, immediate family member, or legal guardian. If you are assisting the applicant in completing this form, please provide your name and and relation to patient. Following completion, please return the questionnaire to Boys Town National Research Hospital.

2. **A copy of your most recent audiogram and audiology history**
   Copies of audiograms obtained at Boys Town Hospital do not need to be sent.

3. **Copy of your insurance card(s)**

4. **List of any prescription medications you are currently taking**

5. **List of your immunizations**

4. **Release of Information forms**
   To be completed and signed by the patient or legal guardian and returned to Boys Town Hospital. These forms allow BTNRH to contact your clinican(s) and/or physician(s) to obtain any further audiology or medical information, if needed.

   1. **Audiologist Release Form**
      Please provide the contact information for your current audiologist.
   2. **Physician Release Form**
      Please provide the contact information for your primary care physician.

555 North 30th Street
Omaha, Nebraska 68131
531-355-6511

14040 Boys Town Hospital Road
Boys Town, Nebraska 68010
531-355-6800

www.boystownhospital.org

When completing the Release of Information forms:

- Provide all the needed contact information including physician or clinician's name, physical address of the clinic, hospital, or other agency, phone number, and fax number.
- Please put only **one contact per release**. Request additional release of information forms from Terri Wolf if needed (e.g., If you see various audiologists at different clinics/hosptials, each will require a unique Release of Information form).
- All the release forms **MUST** be signed by the patient or legal guardian.
- Please return the completed and signed forms to the cochlear implant office.
- If you see a physician or clinician within Boys Town Hospital, you do not need to provide the address. Still provide the name of the physician or clinician and state "Boys Town Hospital" in the address section.

As soon as all questionnaires and records are received, we will continue processing the evaluation request. Please note: if your audiogram is more than 6-12 months old, an updated audiogram is necessary for team review. If you are unable to have this testing conducted by your regular hearing health provider, our team will schedule you for a hearing test to be completed at Boys Town National Research Hospital. In some cases, this will need to be done before proceeding with scheduling a full implant candidacy evaluation.

External records can be faxed to 531-355-5028.

All information received by Boys Town National Research Hospital is confidential. No information will be released without patient's permission.

Optional: Research opportunities are available at the Lied and Learning Technology Center. Please review research information included in the enclosed research brochure. For more information on cochlear implants and research, visit: www.boystownhospital.org/research.

Sincerely,

Terri Wolf
Coordinator, Patient Services
Cochlear Implant & Speech-Language
Lied Learning and Technology Center
425 North 30th Street
Omaha, NE 68131
531-355-5698
Terri.Wolf@boystown.org

Cochlear Implant Center

Boys Town National Research Hospital's Cochlear Implant Center has served hundreds of children and adults with hearing loss since 1991.

The Cochlear Implant Center provides comprehensive clinical services and conducts research related to cochlear implants. The cochlear implant team provides multidisciplinary services to implant candidates and recipients, including support for families. The team's mission is to support the option of cochlear implants for children and adults by utilizing an individualized, family-centered approach to maximize auditory potential.

Team of Specialists

The Center's staff includes professionals with extensive experience and knowledge in cochlear implants and areas related to deafness. Members of the multi-disciplinary team at the Center include:

- Otologists (surgeons)
- Audiologists
- Aural (Re)Habilitation Specialists
- Speech-Language Pathologists
- Parent-Infant Specialists
- Deaf Educators
- Counselors
- Psychologists
- Researchers

Cochlear Implant Candidacy

Cochlear Implant candidates include children and adults who meet the following criteria:

- Severe to profound hearing loss for a broad range of pitches in at least one ear
- Great difficulty understanding spoken communication even with the use of hearing aids

Individualized Evaluation

Every potential candidate receives an individualized evaluation from our team of specialists. This evaluation assists the candidate and his/her family in making an informed decision regarding a cochlear implant. Evaluations are based on the individual's needs and may include:

- Audiological assessment
- Ear, nose and throat (ENT) examination
- Cochlear implant orientation
- Baseline auditory skill evaluation
- Baseline speech-language evaluation
- Communication assessment

- Expectations discussion
- Computed Tomography (CT) and/or Magnetic Resonance Imaging (MRI)
- Vestibular Evaluation

Program Features

A team of professionals with combined decades of experience in providing a variety of services to individuals with hearing loss, including:

- Information dissemination
- Candidacy evaluation
- Specialists teaming to provide holistic treatment
- Surgery
- Intraoperative cochlear implant testing
- Postoperative electrophysiological testing
- Cochlear implant programming
- Individual and group remediation
- Consultation for schools
- Tele-therapy
- Support for a range of communication methods, including sign and spoken language

On-going Collaboration

Boys Town National Research Hospital is committed to ongoing collaboration with each child's education program in order to facilitate maximum benefit from the cochlear implant. Collaboration may include:

- On-going feedback after speech processor programming
- Updates on auditory and speech-language development
- Educational consultation and coaching
- Multidisciplinary evaluations

Location

Cochlear implant services are provided at the **Lied Learning and Technology Center for Childhood Deafness and Vision Disorders**.

The Center is located on the Boys Town Medical Campus in downtown Omaha.

boystownhospital.org/hearingservices/cochlearimplant

2006-232-02

Cochlear Implants Q&A

How does a cochlear implant work?

1. External speech processor captures sound and converts it into digital signals
2. Processor sends digital signals to internal implant
3. Internal implant converts signals into electrical energy sending it to an electrode array surgically implanted inside the cochlea
4. Electrodes stimulate hearing nerve, bypassing damaged hair cells. The brain learns to perceive these signals as sound.

Who is a candidate for a cochlear implant?

The criteria for cochlear implant candidacy are constantly changing as a result of new technology and research outcomes. Current FDA-approved cochlear implant criteria are as follows:

- Age 12 months or older
- Severe to profound hearing loss for at least some pitches and in at least one ear
- Limited benefit or progress with appropriately fit hearing aids
- No medical reason or physical condition that makes it inadvisable for surgery
- Realistic expectations and commitment to follow-up appointments

How is cochlear implant candidacy determined?

The first step is to complete a questionnaire that allows the implant team to screen for potential candidacy. The following appointments with our multi-disciplinary team are typically included in the comprehensive cochlear implant evaluation offered by Boys Town National Research Hospital's Cochlear Implant Program:

- Audiological evaluation
- Cochlear implant orientation
- Radiologic evaluation (MRI and/or CT scan)
- Medical evaluation
- Speech/language evaluation or assessment of communication function
- Vestibular evaluation
- Expectations discussion
- Other evaluations as necessary, which may include appointments with a neurologist, psychologist, geneticist, eye specialist, occupational therapist, physical therapist, counselor, etc.

What services are offered at Boys Town National Research Hospital?

In addition to comprehensive cochlear implant evaluation and surgical services, Boys Town National Research Hospital offers these follow-up services for cochlear implant recipients:

- Intra-operative cochlear implant testing
- Baseline X-ray after surgery
- Cochlear Implant speech processor programming
- Speech and language evaluation and therapy
- Auditory learning sessions
- Speech perception testing
- Electrophysiological testing and troubleshooting
- Medical follow-up
- Consultation with educational settings
- Comprehensive multidisciplinary evaluations, including academic, intellectual, communication and functional auditory assessments
- Assistance in obtaining replacement parts and loaner equipment
- Hearing aid testing and dispensing
- Opportunities to participate in cochlear implant research
- Secure webcasting of initial activations of cochlear implants or other appointments at the family's request

Cochlear implant services offered by the Center for Childhood Deafness, Language, and Learning are provided at the Lied Learning and Technology Center for Childhood Deafness and Vision Disorders.

For more information, contact:

Lied Learning and Technology Center
Boys Town National Research Hospital
425 North 30th Street
Omaha, Nebraska 68131
531-355-5000
Fax: 531-355-5028
Email: terri.wolf@boystown.org

boystownhospital.org/hearingservices/cochlearimplant

BOYS TOWN National Research Hospital

Form No. 253 5/2020

Cochlear Implant Adult Questionnaire

Date: *

Person completing this form: * **Relationship to patient:** *

Patient Name: * Birthdate: Gender: ○ Male ○ Female

Address:

City: State: Zip:

☐ Personal Home ☐ Apartment ☐ Assistive Living ☐ Nursing Home ☐ Other:

Mailing Address (If different from above):

Main Phone: ○ Landline ○ Cell phone

Alt. Phone: ○ Landline ○ Cell phone

Work Phone: ○ Landline ○ Cell phone

E-Mail:

What is the best way to contact you during the daytime? *(Please be aware that we are unable to send texts)*

☐ Main Phone ☐ Alt. Phone ☐ Work Phone ☐ E-mail

Employed: ☐ Full-time ☐ Part-Time ☐ Retired ☐ Not Employed Currently

Occupation:

Place of Employment:

Primary Language/ Language(s) spoken at home:

Do you need an interpreter for your appointment? ○ Yes ○ No

If yes, please specify type: ☐ Spanish ☐ ASL ☐ Signed English ☐ Other:

What is the highest level of education you have completed?

☐ Some high school, no diploma ☐ High school diploma or GED ☐ Some college level courses

☐ Associates Degree ☐ Bachelor's degree ☐ Master's or doctorate degree

Hearing Related Medical History

1. When did you first notice your hearing loss?
2. a. Was the onset of your hearing loss: ○ Slow/Progressive ○ Sudden

   b. If sudden, please describe the onset in detail:
3. When were you officially diagnosed with hearing loss?
4. Has your hearing loss changed over time? ○ Yes ○ No
5. a. If yes, please describe the change(s) ☐ Slow/Progressive ☐ Sudden decreases ☐ Fluctuating

   b. Please provide details:
6. Did you lose your hearing in both ears at the same time? ○ Yes ○ No
7. Is there one ear that is your "better hearing ear?" ○ Yes ○ No If yes, which ear: ○ Right ○ Left
8. When and where was your last hearing test:
9. Do you know the cause of your hearing loss? ○ Yes ○ No If yes, please check all that apply:

   ☐ Otosclerosis ☐ Noise Related ☐ Meningitis (at age):

   ☐ Drugs/Medication (Specify): ☐ Syndrome (Specify):

   ☐ Genetic/Hereditary (Specify):

   ☐ Other (Specify):

Patient Name:*

Cochlear Implant Adult Questionnaire

Hearing Related Medical History-*Continued*

10. a. Is there any hearing loss within your immediate or extended family? ○ Yes ○ No

b. If so, for whom, what was the diagnosis, and at what age?

11. a. Have you had frequent exposure to any of the following? (Check all that apply)

☐ Gunfire ☐ Loud machinery ☐ Loud music ☐ Loud engines (motorcycles, planes, tractors, etc.)

b. If so, please provide details:

c. If yes, did you wear ear protection during this exposure?

12. a. Did you serve in the military? ○ Yes ○ No

b. If so, what service and how many years?

13. Please indicate if you have ever experienced any of the following problems or symptoms listed below:

Symptom/Problem	Which Ear(s)		Please provide details including the frequency and severity:
☐ Ringing in the ears	R ☐	L ☐	
☐ Ear infections	R ☐	L ☐	
☐ Ear fullness	R ☐	L ☐	
☐ Ear injury	R ☐	L ☐	
☐ Ear surgery	R ☐	L ☐	
☐ Drainage	R ☐	L ☐	
☐ Dizziness			
☐ Imbalance			

14. a. Have you had any medical imaging of your ears or head? ○ Yes ○ No

b. If yes, when and where?

c. If yes, what type of imaging? ☐ X-ray ☐ CT scan ☐ MRI ☐ I don't know

Amplification History

15. Please describe below what kind(s) of amplification devices you have tried or currently use? (*Please check all that apply.*)

Device	When was the device fit?	Ear(s)		Device Brand/Model
☐ Hearing Aid		R ☐	L ☐	
☐ CROS[1] or BiCROS[2]		R ☐	L ☐	
☐ BCD[3]/AOD[4] (e.g., BAHA[5])		R ☐	L ☐	
☐ Personal FM System		R ☐	L ☐	
☐ Never fit with amplification				

[1]*Contralateral Routing of Signal (CROS),* [2]*Bilateral CROS (BiCROS),* [3]*Bone Connection Device,* [4] *Auditory Osseointegrated Device (AOD),* [5]*Bone Anchored Hearing Aid*

16. What device(s) do you currently use?

17. Where and from whom were the device(s) dispensed? ·

18. How many hours a day do you wear the device(s)?

19. If you do not wear your device(s) fulltime, what prevents full-time use?

Patient Name:* _____ Cochlear Implant Adult Questionnaire

Communication

20. How do you communicate with others in person? (*Please check all that apply.*)
☐ Spoken Language ☐ American Sign language (ASL) ☐ Signed Exact English (SEE)
☐ Written statements (e.g. white board, notepad) ☐ Other: _____

21. Are you able to understand spoken language via the telephone? ○ Yes ○ No

22. What is your preferred method of distance communication with friends and family?
☐ Spoken calls ☐ Captioned calls ☐ Video communication ☐ Text messages ☐ E-mails

23. a. Have you ever used an FM system to understand speech in noise or at a distance? ○ Yes ○ No
b. If yes, please describe the FM system and when it was/is used:

24. a. Have you ever used any other form of assistive listening devices? (i.e., amplified telephones, loop systems, etc.) ○ Yes ○ No
b. If yes, please describe the technology and how it is/was used:

25. a. Have you ever used any type of alerting device for sounds you cannot hear? (i.e., visual door bell, vibrating alarm clock, etc.) ○ Yes ○ No
b. If yes, please describe the technology and how it is/was used:

Medical History

26. Please list below or provide an attached list of your current medications:

27. Have you ever been treated with the following: ☐ Diuretic/"Water pill" ☐ Intravenous antibiotic ☐ Amino glycoside ☐ Long-term aspirin therapy

28. a. Are you allergic to anything? ○ Yes ○ No
b. If yes, please list and describe?

29. a. Do you use a cane, walker, or wheelchair to get around? ○ Yes ○ No
b. If yes, how often do you use the assistive device:

Patient Name:* _____

Cochlear Implant Adult Questionnaire

Medical History Continued

Please list any surgeries, hospitalizations, accidents, or injuries you have had below. Please include specifics (i.e., **where** you were hospitalized/treated, **when**, and for **what reason**).

30. Ear Surgeries:

31. Surgeries:

32. Hospitalizations:

33. Accidents/Injuries:

34. a. Have you ever been diagnosed with or treated for any of the following? *(If the answer is no, please leave blank.)*

	Yes	Not Sure		Yes	Not Sure		Yes	Not Sure
ADD OR ADHD	☐	☐	Diabetes (Type: _____)	☐	☐	Meningitis (Bacterial)	☐	☐
Allergies/Asthma	☐	☐	Depression	☐	☐	Mental health concerns	☐	☐
Balance problems	☐	☐	Head injury/Concussion	☐	☐	Metabolic problems	☐	☐
Arthritis	☐	☐	Genetic syndromes	☐	☐	Muscle problems	☐	☐
Asperger/Autism Spectrum Disorder	☐	☐	Demyelinating disease *(e.g. Multiple Sclerosis)*	☐	☐	Neurodegenerative disease *(e.g. ALS, Parkinson's, Alzheimer's, or Huntington's)*	☐	☐
Blood disorder	☐	☐	Heart problems	☐	☐	Radiation/Chemotherapy	☐	☐
Cancer	☐	☐	Hypertension	☐	☐	Seizures/Epilepsy	☐	☐
Cerebral palsy	☐	☐	Joint or bone problems	☐	☐	Sinus infections	☐	☐
Cleft palate &/or lip	☐	☐	Kidney/Urinary problems	☐	☐	Skeletal malformation	☐	☐
Cognitive Delays	☐	☐	Learning disability	☐	☐	Thyroid problems	☐	☐
Craniofacial surgery	☐	☐	Memory loss	☐	☐	Stroke	☐	☐
Other:								

b. Please explain any "yes" or "not sure" answers:

c. If you have any other formal diagnosis not listed above, please describe below:

Patient Name:* _____ Cochlear Implant Adult Questionnaire

Vision

35. When was your last vision test? _____

36. Do you have vision loss? ○ Yes ○ No (If yes, check all that apply below.)

- ☐ Nearsightedness ("myopia" can see clearly up close but blurry in the distance)
- ☐ Farsightedness ("hyperopia" can see clearly in the distance but blurry up close)
- ☐ Presbyopia (need glasses to read smaller print)
- ☐ Cataract ☐ Diabetic Retinopathy ☐ Optic Nerve Hypoplasia ☐ Retinitis Pigmentosa
- ☐ Coloboma ☐ Macular Degeneration ☐ Neurological/Cortical Vision Impairment ☐ Glaucoma
- ☐ Not Sure ☐ Other _____

37. a. Do you wear glasses? ○ Yes ○ No

b. If yes, is your vision corrected to normal? ☐ Yes ☐ No ☐ Not Sure ☐ N/A

Understanding Your Needs and Concerns

Your responses to the questions below will help us to get to know you and better understand your concerns.

38. With whom do you spend most of your time?

39. What affect has your hearing loss had on you and those closest to you?

40. If you are currently employed, what challenges do you face at work because of your hearing loss?

41. What activities are you involved in within or outside of your home?

42. How has hearing loss affected these activities?

43. On a rating scale of 1 to 10, how interested are you in receiving a cochlear implant and why?

44. What do you hope to gain with a cochlear implant?

45. What are your greatest fears regarding cochlear implantation?

46. What questions would you like answered during your cochlear implant candidacy evaluation?

47. Is there any other information of which you feel the team should be aware?

48. a. Were you referred for this assessment? ○ Yes ○ No

b. If yes, by whom? _____

Patient Name: *

Cochlear Implant Adult Questionnaire

49. Who are the most important people in your life?

Name	Age	Gender	Lives with you?	Has Hearing Loss?	Relationship
		M ○ F ○	Y ○ N ○	Y ○ N ○	
		M ○ F ○	Y ○ N ○	Y ○ N ○	
		M ○ F ○	Y ○ N ○	Y ○ N ○	
		M ○ F ○	Y ○ N ○	Y ○ N ○	
		M ○ F ○	Y ○ N ○	Y ○ N ○	

Listening and Communication Questionnaire

The following questions inquire about your ability and experiences hearing and listening in different situations. For each question, put a check in one of the five categories that best describes your experiences.

One-on-One Conversations in Quiet	Never	Rarely	Sometimes	Often	Always
1. I can follow a conversation with one other person in a quiet environment when I can see the talker's lips and face.	☐	☐	☐	☐	☐
2. I can follow a conversation with one other person in a quiet environment without looking at the talker.	☐	☐	☐	☐	☐
One-on-One Conversations in Noise	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
3. I can follow a conversation with one other person in a noisy environment when I can see the talker's lips and face.	☐	☐	☐	☐	☐
4. I can follow a conversation with one other person in a noisy environment without looking at the talker.	☐	☐	☐	☐	☐
Group Conversations in Quiet Environments	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
5. I can follow a group conversation in a quiet environment when I can see their lips and faces.	☐	☐	☐	☐	☐
6. I can follow a group conversation in a quiet environment without looking at the talkers.	☐	☐	☐	☐	☐
Group Conversations in Noise	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
7. I can follow a group conversation in a noisy environment when I can see their lips and faces.	☐	☐	☐	☐	☐
8. I can follow a group conversation in a noisy environment without looking at the talkers.	☐	☐	☐	☐	☐
Other Situations	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
9. I can understand a person talking more than 10 feet away.	☐	☐	☐	☐	☐
10. I can follow television programs without reading the closed captions.	☐	☐	☐	☐	☐
11. I can follow conversations over the telephone without using captions.	☐	☐	☐	☐	☐
12. I feel confident talking with strangers despite my hearing loss.	☐	☐	☐	☐	☐
13. I enjoy social gatherings despite my hearing loss.	☐	☐	☐	☐	☐
14. I feel safe going outside my home or going to new places.	☐	☐	☐	☐	☐
15. I feel close to my family and friends despite my hearing loss.	☐	☐	☐	☐	☐
16. I rely on someone to help me communicate with others.	☐	☐	☐	☐	☐
17. I spend a lot of energy concentrating when listening to spoken communication, and I feel tired at the end of the day due to the listening effort I put forth.	☐	☐	☐	☐	☐

Patient Name:*

Cochlear Implant Adult Questionnaire

Expectations Questionnaire

50. Please mark the following statements as **true** or **false**

○ T	○ F	All cochlear implant recipients are able to understand speech at initial activation.
○ T	○ F	Speech will sound natural to all cochlear implant recipients.
○ T	○ F	Cochlear implant recipients no longer need to speechread/lipread.
○ T	○ F	Cochlear implant recipients can understand speech in background noise easily.
○ T	○ F	Television programs are easy to understand for cochlear implant recipients.
○ T	○ F	Cochlear implant recipients report that music sounds natural.
○ T	○ F	All cochlear implant recipients can determine the location of a sound without visual cues.
○ T	○ F	All cochlear implant recipients can communicate over the telephone.
○ T	○ F	Insurance will cover all equipment costs.
○ T	○ F	Cochlear implant recipients no longer have hearing loss.
○ T	○ F	All cochlear implant recipients eventually have the same hearing abilities.
○ T	○ F	Cochlear implant recipients will lose their natural hearing in the ear implanted after surgery.
○ T	○ F	Recipient's outcomes are dependent on how much hearing loss they had prior to implantation.
○ T	○ F	Recipient's outcomes are dependent on if they used a hearing aid prior to implantation.
○ T	○ F	Recipient's outcomes are dependent on how much they use their devices.

Additional Information

51. Please let us know if you would like more information or are interested in any of the following opportunities listed below:

- ☐ Receive information about caption phones
- ☐ Receive information about FM systems or other assistive listening devices
- ☐ Receive information about alerting devices for people with hearing loss
- ☐ Meet or speak with a recipient of a cochlear implant

Medical Records and Insurance Information

52. a. Primary Care Physician:

b. Location:

c. Primary Insurance: Secondary Insurance:

d. Other:

53. Please complete and return the following items along with this form:

- ☐ Copy of audiogram
- ☐ Signed medical release form
- ☐ Copy of your insurance cards
- ☐ Immunization records

Send the most recent copies of the items listed above to:

Mailing Address:	Fax Number:	Email:
Cochlear Implant Patient Manager BTNRH/CCD 555 N. 30th Street Omaha NE 68131	531-355-5028	CITeam@boystown.org

If you have any questions, call the Cochlear Implant Patient Manager at 531-355-5059

For Office Use Only:

Reviewing Clinician's Name: Date Reviewed: Date Reviewed w/Team:

Clinician's Signature:

Signature: *

Email: *

BOYS TOWN National Research Hospital

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Fax: 531-355-0006
Email: medical.records@boystownhospital.org

MR# _____

Patient Name: _____ Date of Birth: _____
Address (including City/State/Zip)_____
_____
Phone Number: _____ Email _____@_____

Release Information From:	**Release Information To:**
Provider/Facility Name: _____	_____
_____	_____
Address: _____	Address: _____
City/State/Zip: _____	City/State/Zip: _____
Phone: _____ Fax _____	Phone: _____ Fax _____

Information to be Released: **Service Dates:** From: _____ To: _____

	Clinic				Hospital		Ancillary		Other
☐	Allergy	☐	Neurology	☐	Anesthesia Records	☐	CT/MRI	☐	Immunization Record
☐	Audiology/Cochlear	☐	Ophthalmology	☐	Behavioral Health/IRTC	☐	EEG	☐	Itemized Billing Records
☐	Craniofacial	☐	Orthopedic	☐	Consultation Reports	☐	EKG	☐	Nutrition
☐	Ear, Nose, Throat	☐	Pediatric	☐	Discharge Summary	☐	Lab	☐	School/Work Release
☐	GI	☐	Psychiatry	☐	History & Physical	☐	Sleep Study	☐	Verbal Communication
☐	Internal Medicine	☐	Speech & Language	☐	Operative Report	☐	X-ray		
Other:									

Purpose for which information is to be used:

☐ Treatment/Referral ☐ Insurance ☐ Evaluation
☐ Changing Doctors ☐ Personal/At Request of Patient ☐ Other (Please specify)

State and federal law protect the following information. Please check the box if you want to include this information with your records.

☐ Alcohol, Drug, or Substance Abuse Records ☐ HIV Testing & Results

Release Format: ☐ Paper ☐ CD/DVD **Release Method:** ☐ Mail ☐ Pick up ☐ Fax ☐ Email ☐ Portal

By signing this authorization form, I understand that:

- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Medical Records Department at Boys Town National Research Hospital at 555 North 30th St. Omaha, NE 68131. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will expire in one year from the date signed or on the following date/event/condition _____, whichever occurs sooner.
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.
- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I acknowledge that I have read and fully understand the E-mail Consent Form on the back of this form and that all record disclosures via email shall be encrypted.

Patient or person authorized to sign for patient

Relationship to Patient

Witness

Date

BOYS TOWN NATIONAL RESEARCH HOSPITAL
E-MAIL CONSENT FORM

1. **Risk of Using E-mail**

Transmitting patient information by e-mail has a number of risks that patients should consider before using e-mail. These include, but are not limited to, the following risks:

- E-mail can be circulated, forwarded and stored in numerous pages and electronic files.
- E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients.
- E-mail senders can easily misaddress an e-mail.
- E-mail is easier to falsify than handwritten or signed documents.
- Backup copies of e-mail may exist even after the sender or the recipient(s) has deleted his or her copy.
- Employers and on-line services have a right to archive and inspect e-mails transmitted through their systems.
- E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
- E-mail can be used to introduce viruses into computer systems.
- E-mail can be used as evidence in court.

2. **Conditions for the Use of E-mail**

BTNRH will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, BTNRH cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by BTNRH's intentional misconduct. Thus, patients must consent to the use of e-mail for patient information. Consent to the use of e-mail includes the patient's express agreement with the following conditions:

a. All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patient's medical records. Other individuals authorized to access the medical records, such as staff and billing personnel, will have access to those e-mails.
b. Provider may forward e-mails internally to Provider's staff and agents as necessary for diagnosis treatment, reimbursement, and other health care operations, or externally to entities performing contracted services on behalf of BTNRH. Those entities are regulated in the same manner as BTNRH.
c. Although BTNRH will endeavor to read and respond promptly to an e-mail from the patient, BTNRH cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Thus, patients should not use e-mail for medical emergencies or other time-sensitive matters.
d. If the patient's e-mail requires or invites a response from the Provider, and the patient has not received a response within a reasonable time period, it is the patient's responsibility to follow up to determine whether the intended recipient received the e-mail and when the recipient will respond.
e. The patient should not use e-mail for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability or substance abuse.
f. The patient is responsible for informing BTNRH of any types of information the patient does not want to be sent by e-mail, in addition to those set out in 2(e) above.
g. The patient is responsible for protecting his/her password or other means of access to e-mail. BTNRH is not liable for breaches of confidentiality caused by the patient or any third party.
h. It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

3. **Instructions**

To communicate by e-mail, the patient shall:

a. Limit or avoid use of his/her employer's computer.
b. Inform BTNRH of changes to his/her e-mail address.
c. Put the patient's name in the body of the e-mail.
d. Include the category of the communication in the e-mail's subject line, for routing purposes (for example, billing question).
e. Review the e-mail to make sure it is clear and that all relevant information is provided before sending to a BTNRH Provider.
f. Inform BTNRH that the patient received an e-mail from a BTNRH Provider.
g. Take precautions to preserve the confidentiality of e-mails, such as using screen savers and safeguarding his/her computer password.
h. Withdraw consent only by e-mail or written communication to BTNRH.

4. **Patient Acknowledgment and Agreement**

I acknowledge that I have read and fully understand this E-mail Consent Form. I understand the risks associated with the communication of e-mail between my BTNRH Provider and me, and consent to the conditions outlined above. In addition, I agree to these instructions, as well as any other instructions that BTNRH may impose to communicate with patients by e-mail. Any questions I had, were answered. I understand that I may withdraw my consent only by e-mail or written communication to BTNRH, which shall only be effective after receipt by BTNRH.