TEMPLATE

Authorization for Access to Patient Information through a Health Information Exchange Organization

Patient Last Name	Patient First Name	Date of Birth
Patient Address		Patient ID Number

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow my health care providers and health plans to obtain access to my medical records through the health information exchange organization called _________. If I give consent, my medical records from the different places where I get health care can be accessed using a statewide computer network. I can fill out this form once and allow all ___________ Participants (including their agents) who provide me with treatment or care management services to electronically access my information. ________ is a not-for-profit organization that securely shares information about people's health electronically to improve the quality of healthcare and meets the privacy and security standards of HIPAA, the requirements of the federal confidentiality laws, 42 CFR Part 2, and New York State Law. To learn more visit ________'s website at www.______.org.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice:

I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

This consent decision applies to:

- ☐ All ___________ Participants
- ☐ [Name of Treatment Provider Organization Only]
- ☐ ___________ Information Exchange, + [Name of Individual]
- ☐ [Name of Insurance Provider]
- ☐ [Name of Care Management Entity]
- ☐ [Name of Quality Improvement Entity] + [Name of Individual]

One Box is checked below to the left of my choice

☐ **1. I GIVE CONSENT** to access my electronic health information through ___________ to provide health care services which includes treatment services; Insurance eligibility verification; care management activities; and quality improvement activities.

☐ **2. I DENY CONSENT** to access my electronic health information through ___________ unless it is to provide me health care services IN A MEDICAL EMERGENCY ONLY. This pertains only to ___________ Organizations that provide emergency care, such as hospital emergency rooms. Emergency access does not pertain to providers at [Name of Provider Organization] since they do not provide emergency care.

☐ **3. I DENY CONSENT** to access my electronic health information through ___________ for any purpose, even in a medical emergency

If I have questions about this form, I may contact by Benefits Administrator or a Compliance Coordinator at ___________: xxx-xxx-xxxx / compliance@___________.org. I have been provided a copy of this form and if I indicated my consent decision applies to all ___________ Participants, I have been provided with a printed list of all ___________ Participants to whom this consent decision applies.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about the information accessed through ___________ 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.
   - **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.

2. **What Types of Information about You Are Included?** If you give consent, all of your electronic health information will be available through ___________. If you indicated your consent decision applies to all ___________ Participants, this includes information created before and after the date this form is signed. 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 include 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**
   - **Medication and Dosages**
   - **Diagnostic Information**
   - **Allergies**
   - **Substance use history summaries**
   - **Clinical notes**
   - **Discharge summaries**
   - **Employment information**
   - **Living Situation**
   - **Social Supports**
   - **Claims Encounter Data**
   - **Lab Test**
   - **Trauma history summary**

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from ___________. You can obtain an updated list at any time by ___________'s website at www.___________.org or by calling xxx-xxx-xxxx.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one. If you indicate that your consent decision applies to all ___________ Participants that means all Participants will have access to your information as of the date this form was signed.

5. **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. Unless your personally identifying health information is protected by the federal confidentiality laws, these entities may access your information through ___________ for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **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 ___________ at xxx-xxx-xxxx, Ext. x; or visit ___________'s website: www.___________.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/*.

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period**. This Consent Form will remain in effect until the day you change your consent choice or until such time as ___________ ceases operation. If ___________ merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice**. You can change your consent choice at any time by submitting a new Consent Form with your new choice. Organizations that access your health information through ___________ while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records, however if your personally identifying health information is protected by the federal confidentiality laws, these organizations will not be able to further redisclose your information without your consent.

10. **Copy of Form**. You are entitled to receive a copy of this Consent Form**.**