



Managing Patient Consent

February 17, 2023

v2.4

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1. Overview

The consent management application (CMA) is a tool that allows users to update HEALTHeLINK Consent without having to access the patient's medical record. CMA is a separate application from HEALTHeLINK.

2. Help/Support

For HEALTHeLINK™ Support

24/7 Help Desk Support

877.895.4724

Local Help Desk Support

716.842.6343

Additional training materials are available at
www.wnyhealthelink.com/PhysiciansandStaff/TrainingVideos

<https://wnyhealthelink.com/physicians-staff/training-materials/webinars/>

Any update to a patient's consent must have a corresponding consent form. All consent forms must be sent to HEALTHeLINK within 3 business days. Forms can be faxed to the number on the form (716) 206-0039.

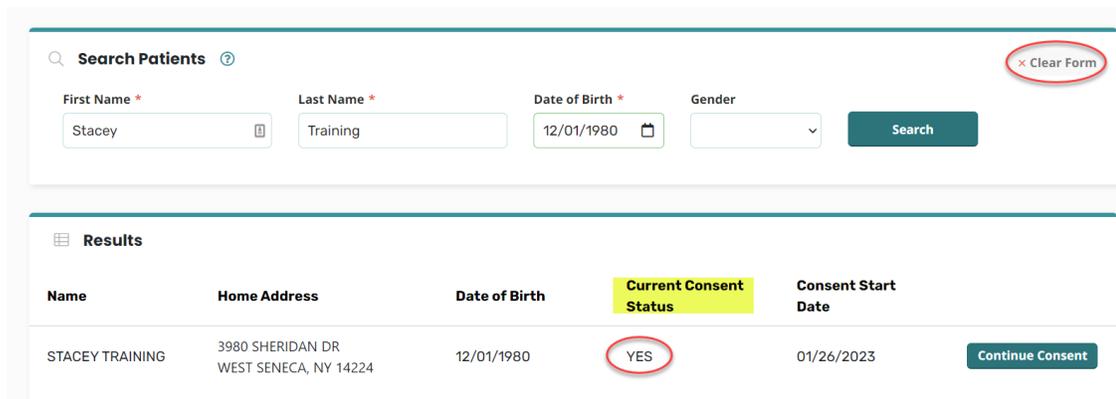
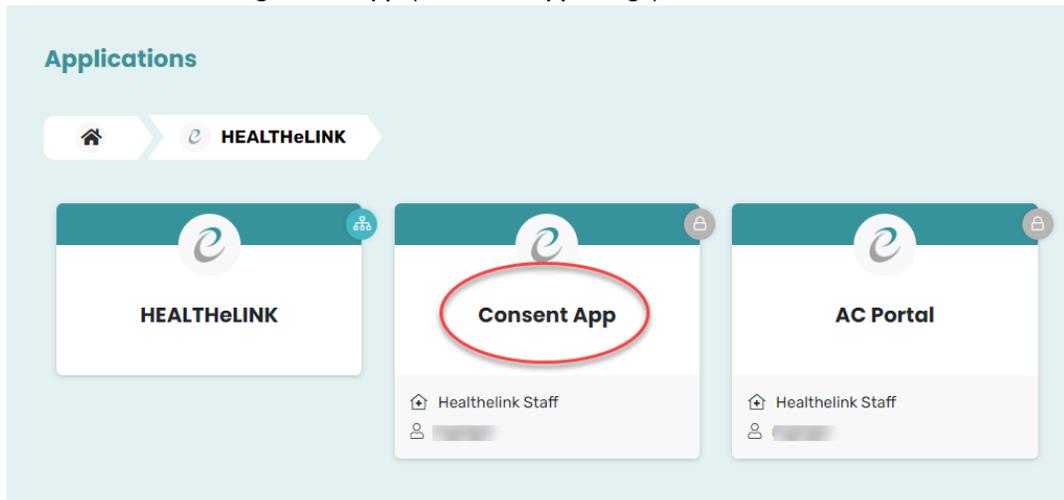
If there is an immediate need to manage the form to allow the access of patient records, fax the completed form to HEALTHeLINK at (716) 206-0996 and call (716) 206-0993 option 2 to inform HEALTHeLINK staff that the form requires immediate attention. This option is available Monday thru Friday 7:30am-5:00pm ET.

3. Checking for Patient Consent in HEALTHeLINK and HEALTHeNET

Patient consent can be managed 1 of 3 ways:

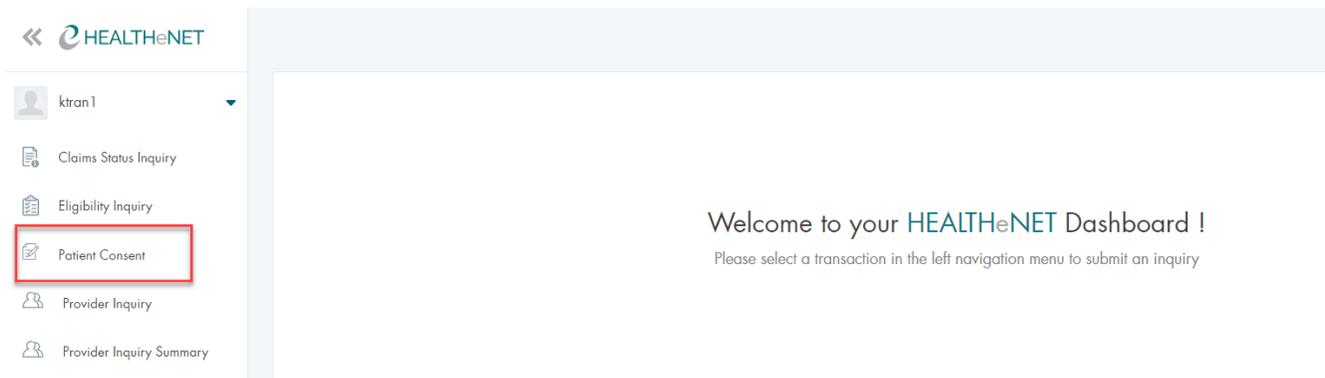
You may search a Patient Consent:

- I. CMA: Consent Management App (Consent App Badge) in HEALTHeLINK.



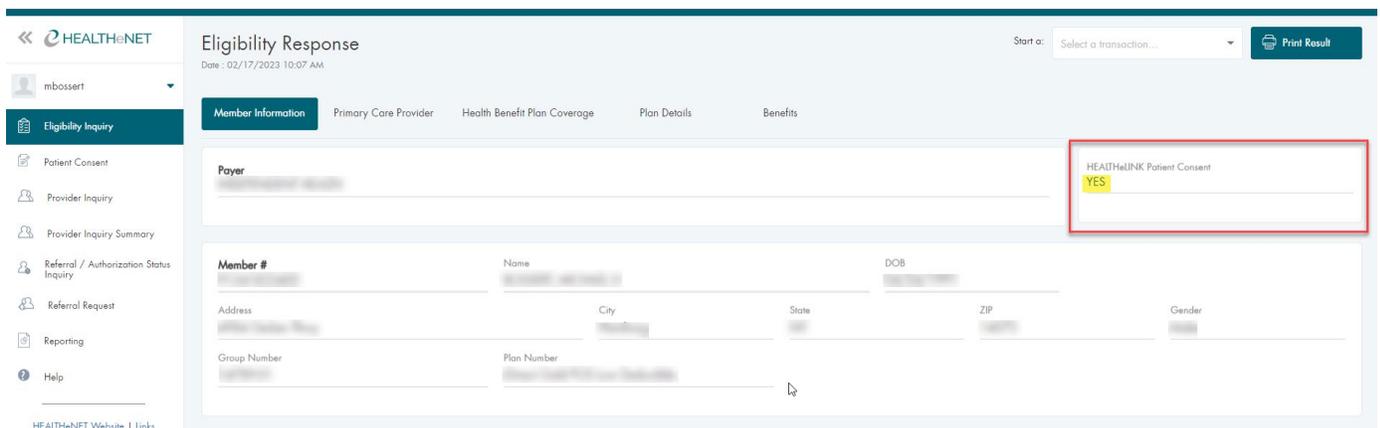
2. HEALTHeNET

- a. Please reach out to your Account Manager if you do not have Patient Consent under HEALTHeNET
- b. Log into HEALTHeNET and click on “Patient Consent”.



3. HEALTHeNET Eligibility

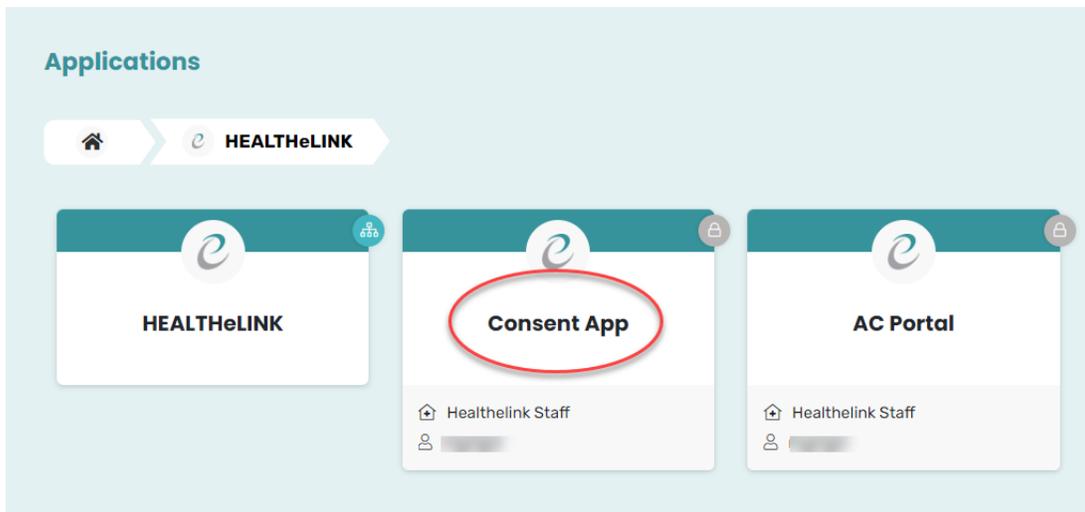
- a. Please reach out to your Account Manager if you do not have Patient Consent under HEALTHeNET.
- b. Log into HEALTHeNET and click on “Eligibility Inquiry”.
- c. Search a patient.
- d. The highlighted text in screenshot is clickable and will take you to the CMA retaining the search criteria (keeping patient context/demographics).



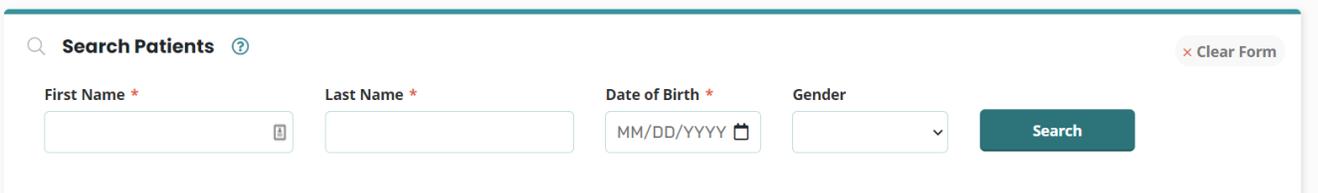
4. Managing Patient Consent in CMA

4.1. Searching for a Patient

1. Log into HEALTHeCOMMUNITY Portal.
2. Select the CMA (Consent App) badge.
 - a. If you have multiple CMA accounts, you must choose the badge that displays the organization you are associated with for the patient you are updating.

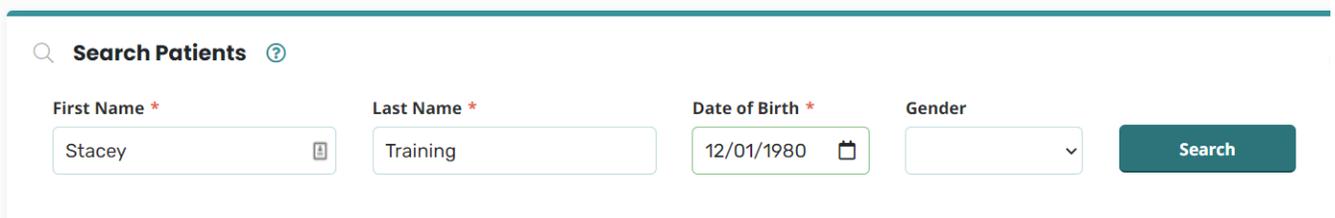


3. Enter search criteria
 - a. First Name, Last Name, and Date of Birth are required. Gender is not required.
 - b. In the case of hyphenated names, a hyphen or space may or may not be needed between the names (Jones-Smith vs. Jones Smith vs. JonesSmith).
 - c. A suffix may or may not be needed as well.



The screenshot shows the 'Search Patients' form. It includes a search icon, a 'Search Patients' label with a help icon, and a 'Clear Form' button. The form has four input fields: 'First Name *', 'Last Name *', 'Date of Birth *' (with a date picker icon), and 'Gender'. A 'Search' button is located to the right of the fields.

4. Click [SEARCH]



The screenshot shows the 'Search Patients' form with the following values entered: 'First Name *' is 'Stacey', 'Last Name *' is 'Training', 'Date of Birth *' is '12/01/1980', and 'Gender' is empty. The 'Search' button is highlighted.

View Tip Sheet: Use this to reference the options of managing consent.

Search Patients 

First Name *

Last Name *

Help

Patient Consent Tip Sheet

UPDATE PATIENT CONSENT
Users may use this feature to lookup and update consent for a single patient.

Patient Information - Required
Enter all of the following fields:

- First Name
- Last Name
- Date of Birth

If one or more matches are found, the consent status will be displayed. If the consent status is "YES" no action is necessary. If consent status is "NO" or "EMERGENCY_ONLY" and the patient wishes to change this, you can click the "PRINT CONSENT" button to populate a consent form with the patient information pre-filled. Collect the patient signature and send HEALTHeLINK the completed form to finish processing. If the status is "UNKNOWN" you can update the status from this link using the guidelines below.

Select "CONTINUE CONSENT"

Select the appropriate value:

- Yes - Allows access to your health information by treating providers.
- No - EXCEPT Specific Participant(s) - Allow access to your health information by all treating providers EXCEPT the

4.2. YES Consent

The search results will display the patient's current consent status as well as the date the consent was signed. If consent status is **YES**, there is no need to collect a new consent unless the patient would like to change their consent value (Follow steps under 4.3). You can then choose CLEAR FORM as no further action is required.

Search Patients  

First Name * Date of Birth * Gender

Results

Name	Home Address	Date of Birth	Current Consent Status	Consent Start Date	
STACEY TRAINING	3980 SHERIDAN DR WEST SENECA, NY 14224	12/01/1980		01/26/2023	<input type="button" value="Continue Consent"/>

4.3. UNKNOWN Consent

If a patient has a current consent status of UNKNOWN, you will need to click the CONTINUE CONSENT button to obtain and update their current consent status.

Search Patients ⓘ ✕ Clear Form

First Name * Last Name * Date of Birth * Gender

Results

Name	Home Address	Date of Birth	Current Consent Status	Consent Start Date
STACEY TRAINING	3980 SHERIDAN DR WEST SENECA, NY 14224	12/01/1980	UNKNOWN	<input type="button" value="Continue Consent"/>

Choose which option the patient would like their consent updated to by clicking the button next to the desired consent status. To review the definitions of each consent status, hover over the  symbol.

Edit Patient Consent

Patient Information

Name:	STACEY TRAINING
Home Address:	3980 SHERIDAN DR WEST SENECA, NY 14224
Date of Birth:	12/01/1980
Current Consent Status:	UNKNOWN
Consent Start Date:	01/01/0001

Update Consent Status

Authoring Facility:	Landmark Medical Pc
---------------------	---------------------

Yes 

Yes, EXCEPT Specific Participant(s) 

Yes, ONLY Specific Participant(s) 

No, EXCEPT in an Emergency 

No, EVEN in an Emergency 

Definitions of Consent:

- **YES** – Allows access to your health information by all treating providers.
- **YES, EXCEPT Specific Participant(s)** – Allows access to your health information by all treating providers EXCEPT the providers selected.
- **YES, ONLY Specific Participant(s)** – Allows access to your health information ONLY to the providers selected. (At least one provider needs to be selected or you will get an error message when updating).
- **NO, EXCEPT in an emergency** – Does not allow access to your health information EXCEPT in the case of an emergency. (At least one provider needs to be selected or you will get an error message when updating).
- **NO, EVEN in an emergency** – Does not allow access to your health information in any case.

Click on the “Print Consent” button to populate the computer-generated consent form. (This will automatically pull the patient’s demographics).

Yes ⓘ

Yes, EXCEPT Specific Participant(s) ⓘ

Yes, ONLY Specific Participant(s) ⓘ

No, EXCEPT in an Emergency ⓘ

No, EVEN in an Emergency ⓘ

A .pdf form will download. Click on the .pdf to pull up the consent.

 consent_form_Refere....pdf ^

Once form is printed, obtain the patient’s signature and consent value option.

Important: This must be the patient’s actual signature via pen & paper, or a stylus & signature pad.



Authorization for Access to Patient Information Through HEALTHeLINK™

Patient First Name STACEY		
Patient Last Name TRAINING		
Date of Birth 12/01/1980	Patient Address 3980 SHERIDAN DR WEST SENECA, NY 14224	Gender <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female

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 Participating HEALTHeLINK Providers and Payers ("Participants") who are involved in my care to obtain access to my medical records through the health information exchange organization called HEALTHeLINK. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. HEALTHeLINK is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit HEALTHeLINK's website at <http://wnyhealthelink.com/>.

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.

S E L E C T O N L Y O N E	My Consent Choice. Only ONE box is checked to the left of my 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.	
	<input type="checkbox"/> 1. YES	I GIVE CONSENT to all current and future Participants, who are involved in my care, to access ALL of my electronic health information through HEALTHeLINK.
	<input type="checkbox"/> 2. YES, EXCEPT SPECIFIC PARTICIPANT(S)	I GIVE CONSENT to all current and future Participants, who are involved in my care, to access ALL of my electronic health information through HEALTHeLINK, EXCEPT the Participant(s) listed below. Participant's Name (Provider Office): _____ Participant's address or phone number: _____ _____ _____
	<input type="checkbox"/> 3. YES, ONLY SPECIFIC PARTICIPANT(S)	I GIVE CONSENT ONLY to the specific Participant(s) listed below to access ALL of my electronic health information through HEALTHeLINK. Participant's Name (Provider Office): _____ Participant's address or phone number: _____ _____ _____
	<input type="checkbox"/> 4. NO, EXCEPT IN AN EMERGENCY	I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY for current and future Participants to access my electronic health information through HEALTHeLINK.
<input type="checkbox"/> 5. NO, EVEN IN AN EMERGENCY	I DENY CONSENT for current and future Participants to access my electronic health information through HEALTHeLINK for any purpose, even in a medical emergency.	

I understand that my information may be accessed in the event of an emergency, unless I complete this form and check box #5, which states that I deny consent even in a medical emergency.

I understand that upon my request, HEALTHeLINK is required to provide me with a list of disclosures of my electronic health information under the terms of this form.

My questions about this form have been answered and I have been provided a copy of this form if I request it.

Signature of Patient or Patient's Legal Representative X _____	Signature Date 02/17/2023	Print Name of Patient's Legal Representative (if applicable) Relationship of Legal Representative to Patient (if applicable) <input type="checkbox"/> Parent <input type="checkbox"/> Healthcare agent/proxy <input type="checkbox"/> Guardian <input type="checkbox"/> Other _____
		Practice Name Here _____ Entry Consent Received By

Rev. 1 (11-15-18) 2475 George Urban Boulevard, Suite 202, Depew New York 14043 / Dedicated Fax Line: 716-206-0039 **CMA-01**
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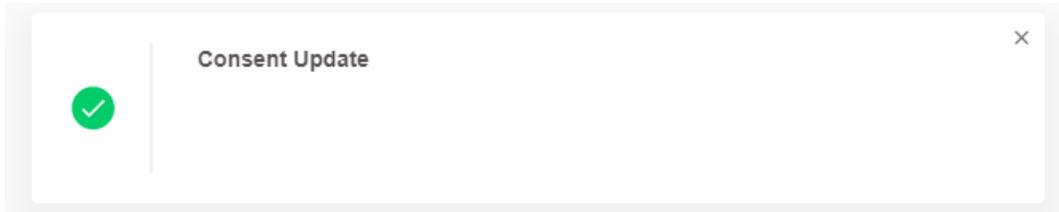
Attestation will appear for confirmation.

HEALTHeLINK Consent Update Attestation

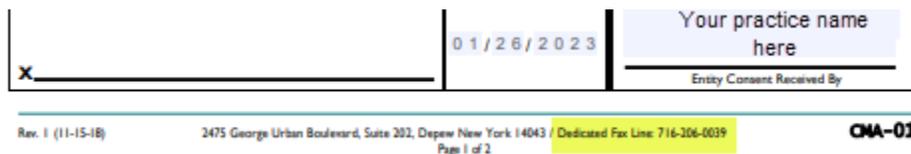
I have obtained a valid consent form, signed and dated by the patient, and the Date of Signature is valid and is more current than previous date of consent, if applicable. That form has been or will be faxed to HEALTHeLINK at 716-206-0039.

Back
Continue

A pop up message will briefly display in the bottom right corner of your screen, showing confirmation of a successful update of consent, and you will then have access to the patient's records.



Fax printed and signed consent to HEALTHeLINK's dedicated Fax Line at the bottom of the consent form. The fax # is 716-206-0039.



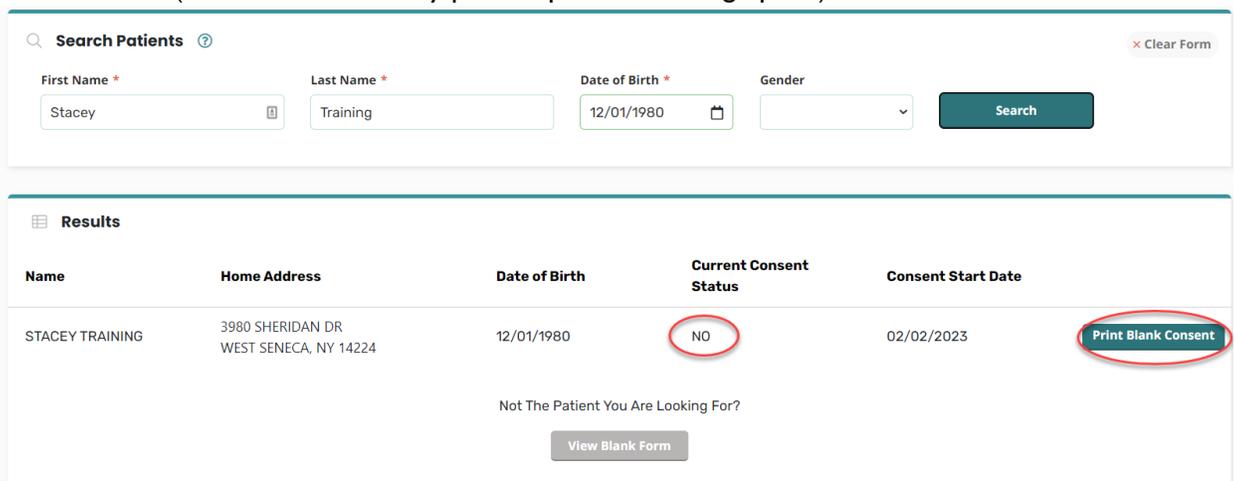
4.4. NO Consent

If the patient is currently consented as either "No, EXCEPT in an emergency" or "No, EVEN in an emergency", there are a series of steps that need to be taken to have this consent properly updated.

If a "NO" or "EMERGENCY ONLY" patient would like to change their consent:

After discussing the options with the patient, the patient has decided they would like to change their consent status. Continue consent as shown below:

1. Click on the "Print Blank Consent" button to populate the computer-generated consent form. (This will automatically pull the patient's demographics).



- A .pdf form will download. Click on the .pdf to pull up the consent



- Once form is printed, obtain the patient's signature and consent value option.

Important: This must be the patient's actual signature via pen & paper, or a stylus & signature pad.

HEALTHeLINK		Authorization for Access to Patient Information Through HEALTHeLINK™	
Patient First Name		STACEY	
Patient Last Name		TRAINING	
Date of Birth	Patient Address	Gender	
12/01/1980	3980 SHERIDAN DR WEST SENECA NY 14224	<input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	
<p>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 Participating HEALTHeLINK Providers and Payers ("Participants") who are involved in my care to obtain access to my medical records through the health information exchange organization called HEALTHeLINK. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. HEALTHeLINK is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit HEALTHeLINK's website at http://www.healthelink.com.</p> <p>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.</p>			
<p>My Consent Choice. Only ONE box is checked to the left of my 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.</p>			
SELECT ONLY ONE	<input type="checkbox"/> 1. YES	I GIVE CONSENT to all current and future Participants, who are involved in my care, to access ALL of my electronic health information through HEALTHeLINK.	
	<input type="checkbox"/> 2. YES, EXCEPT SPECIFIC PARTICIPANT(S)	I GIVE CONSENT to all current and future Participants, who are involved in my care, to access ALL of my electronic health information through HEALTHeLINK, EXCEPT the Participant(s) listed below. Participant's Name (Provider Office): _____ Participant's address or phone number: _____	
	<input type="checkbox"/> 3. YES, ONLY SPECIFIC PARTICIPANT(S)	I GIVE CONSENT ONLY to the specific Participant(s) listed below to access ALL of my electronic health information through HEALTHeLINK. Participant's Name (Provider Office): _____ Participant's address or phone number: _____	
	<input type="checkbox"/> 4. NO, EXCEPT IN AN EMERGENCY	I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY for current and future Participants to access my electronic health information through HEALTHeLINK.	
	<input type="checkbox"/> 5. NO, EVEN IN AN EMERGENCY	I DENY CONSENT for current and future Participants to access my electronic health information through HEALTHeLINK for any purpose, even in a medical emergency.	
<p>I understand that my information may be accessed in the event of an emergency, unless I complete this form and check box #5, which states that I deny consent even in a medical emergency.</p> <p>I understand that upon my request, HEALTHeLINK is required to provide me with a list of disclosures of my electronic health information under the terms of this form.</p> <p>My questions about this form have been answered and I have been provided a copy of this form if I request it.</p>		<p>Print Name of Patient's Legal Representative (if applicable)</p> <p>_____</p> <p>Relationship of Legal Representative to Patient (if applicable)</p> <p> <input type="checkbox"/> Parent <input type="checkbox"/> Healthcare agent/proxy <input type="checkbox"/> Guardian <input type="checkbox"/> Other _____ </p>	
Signature of Patient or Patient's Legal Representative		Signature Date	
X _____		_____/_____/_____	
		Practice Name Here	
		Entity Consent Received By	

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CMA-01

Due to compliance requirements, you are unable to update a "NO" consent in real time. It must be updated by HEALTHeLINK Consent Staff.

When a patient has made the consent change from a "No" consent, further actions are required by the practice to ensure this update is implemented. All forms need to be faxed/sent to HEALTHeLINK within 3 business days.

The following steps should be taken if the patient is present and waiting for treatment:

1. After the patient has signed the form, please fax the form to the EMERGENCY CONSENT FAX LINE: (716) 206-0996.
2. After faxing, you can call our Consent Team to notify them of the incoming fax. Please call (716) 206-0993, option 2.
The team is available Monday- Friday, 7:30am- 5:00pm ET.
3. Once the team has made this update, you should have access to these patient records within 15 minutes.

4.5. Managing Consent for a Patient Not Found in HEALTHeLINK

If there is no corresponding patient listed in HEALTHeLINK, you can generate a blank HEALTHeLINK consent form.

Important: Before proceeding with this step, make sure you have entered the patient information correctly. The most common error is mixing up **patient first** and **last name or misspelling**. **The form will print matching the search criteria that you have provided.** In the case of hyphenated names, a hyphen or space may or may not be needed between the names (Jones-Smith vs. Jones Smith vs. JonesSmith). A suffix may or may not be needed as well.

To generate a consent form for a non-HEALTHeLINK patient,

- I. Click [VIEW BLANK FORM]



No Results Found

No patients were found that match your search criteria. Make sure you are entering the correct information in the proper fields and retry. Otherwise, click the button below.

View Blank Form

- A PDF consent form will be downloaded. The generated form will be pre-populated with the provided search criteria (patient name, date of birth, gender) and your practice information.

HEALTHeLINK Authorization for Access to Patient Information Through HEALTHeLINK™

Patient First Name adult		
Patient Last Name test		
Date of Birth 05/15/1978	Patient Address _____	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

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 Participating HEALTHeLINK Providers and Payers ("Participants") who are involved in my care to obtain access to my medical records through the health information exchange organization called HEALTHeLINK. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. HEALTHeLINK is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit HEALTHeLINK's website at <http://www.healthelink.com/>.

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. Only ONE box is checked to the left of my 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.

SELECT ONE	<input type="checkbox"/> 1. YES	I GIVE CONSENT to all current and future Participants, who are involved in my care, to access ALL of my electronic health information through HEALTHeLINK.
	<input type="checkbox"/> 2. YES, EXCEPT SPECIFIC PARTICIPANT(S)	I GIVE CONSENT to all current and future Participants, who are involved in my care, to access ALL of my electronic health information through HEALTHeLINK, EXCEPT the Participant(s) listed below. Participant's Name (Provider Office): _____ Participant's address or phone number: _____
	<input type="checkbox"/> 3. YES, ONLY SPECIFIC PARTICIPANT(S)	I GIVE CONSENT ONLY to the specific Participant(s) listed below to access ALL of my electronic health information through HEALTHeLINK. Participant's Name (Provider Office): _____ Participant's address or phone number: _____
	<input type="checkbox"/> 4. NO, EXCEPT IN AN EMERGENCY	I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY for current and future Participants to access my electronic health information through HEALTHeLINK.
	<input type="checkbox"/> 5. NO, EVEN IN AN EMERGENCY	I DENY CONSENT for current and future Participants to access my electronic health information through HEALTHeLINK for any purpose, even in a medical emergency.

I understand that my information may be accessed in the event of an emergency, unless I complete this form and check box #5, which states that I deny consent even in a medical emergency.

I understand that upon my request, HEALTHeLINK is required to provide me with a list of disclosures of my electronic health information under the terms of this form.

My questions about this form have been answered and I have been provided a copy of this form if I request it.

Signature of Patient or Patient's Legal Representative X _____	Signature Date / /	Print Name of Patient's Legal Representative (if applicable) _____
		Relationship of Legal Representative to Patient (if applicable) <input type="checkbox"/> Parent <input type="checkbox"/> Healthcare agent/proxy <input type="checkbox"/> Guardian <input type="checkbox"/> Other _____
		Entity Consent Received By Test Practice

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- Print the form.
- Fax the complete form to HEALTHeLINK at the number at the bottom of the consent form.

Please note that there is not an option to update the patient consent for patients not found in HEALTHeLINK. HEALTHeLINK will determine if there is a discrepancy with a current patient, or create a new patient, and apply the consent.

4.6. Yes, Except and Yes, Only Consent

“Yes, EXCEPT Specific Participant(s)” and “Yes, ONLY Specific Participant(s)”

Edit Patient Consent

Patient Information

Name: STACEY TRAINING
 Home Address: 3980 SHERIDAN DR WEST SENECA, NY 14224
 Date of Birth: 12/01/1980
 Current Consent Status: YES
 Consent Start Date: 02/02/2023

Update Consent Status

Authoring Facility: Landmark Medical Pc

Yes ⓘ
 Yes, EXCEPT Specific Participant(s) ⓘ

Allegany County DOH Clinic

Allegany County DOH Public Health

Allentown Pediatric And Adolescent Medicine Llp

Alvarez Md And Leary Md Pc

Close
Print Consent
Update Consent

When a patient updates their consent value to Yes, Except or Yes, Only, you will be prompted to select which participant or participants are applicable.

The downloaded pdf will reflect these practices:

My Consent Choice. Only ONE box is checked to the left of my 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.	
<div style="writing-mode: vertical-rl; transform: rotate(180deg); font-weight: bold; font-size: 1.2em;">S E L E C T</div> <p><input type="checkbox"/> 1. YES</p>	<p>I GIVE CONSENT to all current and future Participants, who are involved in my care, to access ALL of my electronic health information through HEALTHeLINK.</p>
<p><input checked="" type="checkbox"/> 2. YES, EXCEPT SPECIFIC PARTICIPANT(S)</p>	<p>I GIVE CONSENT to all current and future Participants, who are involved in my care, to access ALL of my electronic health information through HEALTHeLINK, EXCEPT the Participant(s) listed below.</p> <p>Participant's Name (Provider Office): Participant's address or phone number:</p> <div style="border: 1px solid #ccc; padding: 2px; margin-top: 5px;"> <p>Buffalo Medical Group</p> </div>

After the consent has been printed and signed, click on “Update Consent”.

Edit Patient Consent

Patient Information

Name:	STACEY TRAINING
Home Address:	3980 SHERIDAN DR WEST SENECA, NY 14224
Date of Birth:	12/01/1980
Current Consent Status:	YES
Consent Start Date:	02/02/2023

Update Consent Status

Authoring Facility: Landmark Medical Pc

- Yes ⓘ
- Yes, EXCEPT Specific Participant(s) ⓘ

Buffalo Medical Group x

- Yes, ONLY Specific Participant(s) ⓘ
- No, EXCEPT in an Emergency ⓘ
- No, EVEN in an Emergency ⓘ

Close

Print Consent

Update Consent

Attestation will appear for confirmation.

HEALTHeLINK Consent Update Attestation

I have obtained a valid consent form, signed and dated by the patient, and the Date of Signature is valid and is more current than previous date of consent, if applicable. That form has been or will be faxed to HEALTHeLINK at 716-206-0039.

Back

Continue

A pop up message will briefly display in the bottom right corner of your screen, showing confirmation of a successful update of consent, and you will then have access to the patient’s records.



Fax printed and signed consent to HEALTHeLINK's dedicated Fax Line at the bottom of the consent form. The fax # is 716-206-0039.

x _____	01/26/2023	Your practice name here Entity Consent Received By _____
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5. Faxing HEALTHeLINK Consents

- **Non-Urgent Consent Updates:**
 - Fax the signed and dated computer-generated form to our HEALTHeLINK Consent line at (716) 206-0039 within 3 business days.

- **Emergency Consent Updates:**

This fax line can only be used if the patient is currently in the office AND would like to change their consent from a “No” or “Emergency Only” to a “Yes”.

- Fax the signed and dated computer-generated form to our **Emergency** HEALTHeLINK Consent line at (716) 206-0996.
- Call the HEALTHeLINK Consent Department at (716) 206-0993, option 2 to notify that there is an emergency consent waiting to be updated. Please note that the phones will only be monitored during regular business hours of Monday–Friday from 7:30am to 5:00pm ET.

6. Helpful Tips

- A “YES” Consent is valid community-wide covering the 8 counties of Western New York. You are not required to collect a new consent unless the patient chooses to change the value. The CMA will prevent a consent from being updated from a Yes to a Yes.
- FOR PEDIATRIC PATIENTS ONLY – If a parent or guardian has signed the minor’s consent, on the day of the patient’s 18th Birthday, the consent value will automatically revert to an “UNKNOWN”. The patient must then sign a new consent as an adult.
- If you are experiencing any issues finding a patient in the CMA, please check the spelling, DOB and the placement of the First Name/Last Name. If issues continue, call the HEALTHeLINK Help Desk.
- To maintain access to the Consent Management (CMA) badge all users are required to login to this badge every 180 days. Failure to do so will result in deactivation.

If you have any questions, please call the HEALTHeLINK Help Desk at 1-877-895-4724 or (716) 842-6343