Authorization for Access to Patient Information Through HEALTHeLINK™

Patient First Name		
Patient Last Name		
Date of Birth / /	**Patient Address** _____ _____	**Gender** ☐ Male ☐ 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.

SELECT ONLY ONE

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.

☐ **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.
☐ **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:
☐ **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:
☐ **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.
☐ **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)

☐ Parent ☐ Healthcare agent/proxy

☐ Guardian ☐ Other_____

_____

Entity Consent Received By

Details about patient information in HEALTHeLINK and the consent process:

1. **How Your Information May Be Used.** With limited exceptions, if you give consent, the Participant(s) you approve may use your electronic health information **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, the Participants you approve may access ALL of your electronic health information available through HEALTHeLINK. This includes information created before and after the date of this Consent Form. 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 relate to sensitive health conditions, including but not limited to:
   - Alcohol or drug use problems
   - HIV/AIDS
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - Mental health conditions
   - Sexually transmitted disease

   If you have received alcohol or drug abuse care, your record may include information related to your alcohol or drug abuse diagnoses, medications and dosages, lab tests, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social supports, and health insurance claims history.

3. **Where Health Information About You Comes From.** Information about you comes from places that have provided you with medical care or health insurance ("Information Sources"). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other eHealth organizations that exchange health information electronically. A complete list of current Information Sources is available from HEALTHeLINK at http://wnyhealthelink.com or by calling 716- 206-0993 ext. 103.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Participant(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one. Your information may also be accessed without your consent by Public Health Agencies if permitted by State and/or Federal Law. Any data received from a 42 C.F.R. Part 2 designated facility (certain providers of alcohol or drug abuse care) may only be accessed where there is a treating provider relationship. A complete list of Participants is available from HEALTHeLINK at http://wnyhealthelink.com/physicians-staff/current-participants/participating-healthelink-providers/ or by calling 716-206-0993 ext. 103 if you want a hard copy, which will be provided at no charge within five (5) business days of the request.

5. **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 one of the Participants you have approved to access our records; or visit HEALTHeLINK's website at http://wnyhealthelink.com; or call HEALTHeLINK at 716- 206-0993 ext. 103; 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/.

6. **Re-disclosure of Information.** Any Participant(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.

7. **Effective Period.** This Consent Form will remain in effect until the day you change your consent choice or until such time as HEALTHeLINK ceases operation ***(or until 50 years after your death whichever occurs first)***. If HEALTHeLINK merges with another Qualified Entity, our consent choices will remain effective with the newly merged entity.

8. **Changing Your Consent Choice.** You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice(s). Participant(s) that access your health information through HEALTHeLINK 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.