

[INSERT ORGANIZATION LOGO HERE]



Health<sub>e</sub>Connections™ Consent Form  
[NAME OF PROVIDER ORGANIZATION]

In this Consent Form, you can choose whether to allow [Name of Provider Organization] to obtain access to your medical records through a computer network operated by Health<sub>e</sub>Connections™, which is part of a statewide computer network. This can help collect the medical records you have in different places where you get health care, and make them available electronically to our office.

You may use this Consent Form to decide whether or not to allow [Name of Provider Organization] to see and obtain access to your electronic health records in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services.**

If you check the “**I GIVE CONSENT**” box below, you are saying “Yes, [Name of Provider Organization]’s staff involved in my care may see and get access to all of my medical records through Health<sub>e</sub>Connections™.”

If you check the “**I DENY CONSENT**” box below, you are saying “No, [Name of Provider Organization] may not be given access to my medical records through Health<sub>e</sub>Connections™ for any purpose.”

Health<sub>e</sub>Connections™ is a not-for-profit organization. It shares information about people’s health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology (health IT). To learn more about ehealth in New York State, read the brochure, “Better Information Means Better Care.” You can ask [Name of Provider] for it, or go to the website [www.ehealth4ny.org](http://www.ehealth4ny.org).

**Please carefully read the information on the back of this form before making your decision.**

**Your Consent Choices.** You can fill out this form now or in the future. You have two choices.

- I GIVE CONSENT for [Name of Provider Organization] to access ALL of my electronic health information through Health<sub>e</sub>Connections™ in connection with providing me any health care services, including emergency care.**
- I DENY CONSENT for [Name of Provider Organization] to access my electronic health information through Health<sub>e</sub>Connections™ for any purpose, even in a medical emergency. NOTE: UNLESS YOU CHECK THIS BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through Health<sub>e</sub>Connections™.**

\_\_\_\_\_  
Print Name of Patient

\_\_\_\_\_  
Patient Date of Birth

\_\_\_\_\_  
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 patient information in Health<sub>e</sub>Connections™ and the consent process:

1. **How Your Information Will be Used.** Your electronic health information will be used by **[Name of Provider Organization]** only to:

- Provide you with medical treatment and related services
- Evaluate and improve the quality of medical care provided to all patients.

**NOTE:** The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

2. **What Types of Information about You Are Included.** If you give consent, **[Name of Provider Organization]** may access ALL of your electronic health information available through the RHIO. 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/treatment
- Birth control and abortion (family planning)
- Genetic (inherited) diseases or tests
- Any mention of HIV/AIDS
- Mental health conditions
- Sexually transmitted diseases

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 Health<sub>e</sub>Connections™. You can obtain an updated list of Information Sources at any time by checking the Health<sub>e</sub>Connections™ website at [www.healthconnections.org](http://www.healthconnections.org) or by calling (315) 671-2241.

4. **Who May Access Information About You, If You Give Consent.** Only these people may access information about you: doctors and other health care providers who serve on **[Name of Provider Organization]’s** medical staff who are involved in your medical care; health care providers who are covering or on call for **[Name of Provider Organization]’s** doctors; and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

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 **[Name of Provider Organization] at: \_\_\_\_\_**; or visit Health<sub>e</sub>Connections™ website: [www.healthconnections.org](http://www.healthconnections.org); or call the NYS Department of Health at 877-690-2211.

6. **Re-disclosure of Information.** Any electronic health information about you may be re-disclosed by **[Name of Provider Organization]** to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS, mental health information and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information. Health<sub>e</sub>Connections™ and persons who access this information through Health<sub>e</sub>Connections™ must comply with these requirements.

7. **Effective Period.** This Consent Form will remain in effect until the day you withdraw your consent or Health<sub>e</sub>Connections™ ceases all operations.

8. **Withdrawing Your Consent.** You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to **[Provider Organization]**. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms on the Health<sub>e</sub>Connections™ website at [www.healthconnections.org](http://www.healthconnections.org), or by calling (315) 671-2241. **Note: Organizations that access your health information through Health<sub>e</sub>Connections™ while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.**

9. **Copy of Form.** You are entitled to get a copy of this Consent Form after you sign it.