Community-Wide Deny Form

To activate the Community-Wide Deny Consent, the patient must complete the form and verify their identity using one of the following options (*refer to full procedures on the following pages*):

1. Present at one of their providers with a Photo ID, complete this form and have signature witnessed by the provider. The provider will send the form securely to HealtheConnections using Secure Messaging to support@hiemail.healtheconnections.org, encrypted email to support@healtheconnections.org, or fax to 1-315-407-0053.
2. Complete this form and have signature notarized. This can be sent to HealtheConnections using USPS mail, fax to 1-315-407-0053, or via email to support@healtheconnections.org.
3. Make an appointment with a Compliance Officer or Manager at HealtheConnections to be seen at the HealtheConnections office. To make an appointment, email support@healtheconnections.org or call 315-671-2241 extension 5 to schedule. During their appointment they will need to provide a Photo ID and complete this form to request a Community-Wide Deny.
4. If the patient does not have a photo identification, please contact HealtheConnections Compliance Officer for alternative methods.

All fields are required.

Patient Information

Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Email Address: _____

I would like confirmation that this Community-Wide Deny has been placed (check one):

☐ Mail ☐ Email ☐ Notification not needed

By signing this document, I deny all organizations participating in HealtheConnections to access my electronic health information through HealtheConnections.

Patient Signature: _____ Date: _____

Provider Name: _____

Organization: _____

Provider Signature: _____ Date: _____

For Notary Public Use Only

State of _____ *County of* _____

On the _____ *day of* _____ *in the year* _____ *before me, the undersigned, personally appeared* _____, *personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he/she/they executed in his/her capacity, and that by his/her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.*

Notary Public Printed Name: _____

Notary Public Signature: _____ *(Stamp or seal)*

My Commission Expires: _____

443 North Franklin St., Suite 001
Syracuse, NY 13204
healtheconnections.org

Community-Wide Deny Consent Policy

A patient has the option to choose Community-Wide Deny Consent. This 'Deny' consent is applied to **ALL** participants of HealtheConnections.

This consent has the following implications:

- This consent will override all other consents at all other facilities that the patient has previously selected. For example, if the patient had selected 'Yes' at their primary care and allergist but is now presenting at a hospital and wants to select 'Community-Wide Deny', their primary care and allergist will not be allowed to access their medical records in the health information exchange.

- In an emergency event, medical personnel will not be able to access the patient's medical records in the health information exchange, which could delay access to vital information from other sources.

- Once this selection has been activated, it can only be changed via the process to revoke a Community-Wide Deny Consent below.

Process to activate the Community-Wide Deny Consent

The patient must do one of the following options:

1. Present at one of their providers with a Photo ID, complete the form and have signature witnessed by the provider. The provider will send the form securely to HealtheConnections using one of the following methods:
    a. Secure Messaging: support@hiemail.healtheconnections.org
    b. Encrypted Email: support@healtheconnections.org
    c. Fax: 1-315-407-0053

2. Complete this form and have signature notarized. This can be sent to HealtheConnections through one of the following options:
    a. United States Postal Service (USPS) mail:
        HealtheConnections
        c/o Privacy Officer
        443 N Franklin St, Suite 001
        Syracuse, NY 13204
    b. Fax: 1-315-407-0053
    c. Email: support@healtheconnections.org

3. Make an appointment with a Compliance Officer or Manager at HealtheConnections to be seen at the HealtheConnections office. To make an appointment, email support@healtheconnections.org or call 315-671-2241 extension 5 to schedule. During their appointment they will need to provide a Photo ID and complete the form to request a Community-Wide Deny.

4. If the patient does not have a photo identification, please contact HealtheConnections Compliance Officer for alternative methods.

Process to revoke Community-Wide Deny Consent

The patient must complete the Community-Wide Deny Consent Revocation form on page 4 of this policy document and do one of the following options:

1. Present at one of their providers with a Photo ID, complete the Revocation form and have signature witnessed by the provider. The provider will send the form securely to HealtheConnections using one of the following methods:
    a. Secure Messaging: support@hiemail.healtheconnections.org
    b. Encrypted Email: support@healtheconnections.org
    c. Fax: 1-315-407-0053

2. Complete the Revocation form and have the signature notarized. This can be sent to HealtheConnections through one of the following options:
    a. USPS mail:
        HealtheConnections
        c/o Privacy Officer
        443 N Franklin St, Suite 001
        Syracuse, NY 13204
    b. Fax: 1-315-407-0053
    c. Email: support@healtheconnections.org

3. Make an appointment with a Compliance Officer or Manager at HealtheConnections to be seen at the HealtheConnections office. To make an appointment, email support@healtheconnections.org or call 315-671-2241 extension 5 to schedule. During their appointment they will need to provide a Photo ID and complete the Revocation form to request removal of Community-Wide Deny Consent.

4. If the patient does not have a photo identification, please contact HealtheConnections Compliance Officer for alternative methods.

Important Note:
HealtheConnections will revoke the Community-Wide Deny Consent for the patient during daily support hours on Monday – Friday from 8am-4:30pm. There will be no after-hours or weekend support to revoke the Community-Wide Deny Consent.

Community-Wide Deny Revocation Form

To revoke the Community-Wide Deny Consent, the patient must complete the Revocation form and verify their identity using one of the following options (*refer to full procedures on the previous pages*):

1. Present at one of their providers with a photo ID, complete this form and have signature witnessed by the provider. The provider will send the form securely to HealtheConnections using Secure Messaging to support@hiemail.healtheconnections.org, encrypted email to support@healtheconnections.org, or fax to 1-315-407-0053.
2. Complete this form and have signature notarized. This can be sent to HealtheConnections using USPS mail, fax to 1-315-407-0053, or via email to support@healtheconnections.org.
3. Make an appointment with a Compliance Officer or Manager at HealtheConnections to be seen at the HealtheConnections office. To make an appointment, email support@healtheconnections.org or call 315-671-2241 extension 5 to schedule. During their appointment they will need to provide a Photo ID and complete this form to request removal of Community-Wide Deny Consent.
4. If the patient does not have a photo identification, please contact HealtheConnections Compliance Officer for alternative methods.

All fields are required.

Patient Information

Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Email Address: _____

I would like confirmation that this Community-Wide Deny Revocation has been processed (check one):

☐ Mail ☐ Email ☐ Notification not needed

By signing this document, I revoke my previous Community-Wide Deny Consent, which denied all Provider Organizations and Health Plans participating in HealtheConnections to access my electronic health information through HealtheConnections.

Patient Signature: _____ Date: _____

Provider Name: _____

Organization: _____

Provider Signature: _____ Date: _____

For Notary Public Use Only

State of _____ *County of* _____

On the _____ *day of* _____ *in the year* _____ *before me, the undersigned, personally appeared* _____, *personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he/she/they executed in his/her capacity, and that by his/her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.*

Notary Public Printed Name: _____

Notary Public Signature: _____ *(Stamp or seal)*

My Commission Expires: _____

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