** indicates required field*

*** Patient Name**	*** Date of Birth**

E-Mail Address for notice confirming change has been made:

In order 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 and complete the form to request Community-wide Deny Consent. The provider will send the form to HealtheConnections.
2. Present at a HealtheConnections office with a photo ID and complete the form to request Community-wide Deny Consent.
3. Patient may request Community-wide Deny Consent form to be completed and notarized. Patient may send form back via mail or fax (315-407-0053).

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

Signature: _____ *Date:* _____

Witness Name: _____ *Organization:* _____

Witness Signature: _____ *Date:* _____

Notarization:

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: _____

My Commission Expires: _____

(seal or stamp)