HEALTHeLINK

Patient Consent to Participate in HEALTHeLINK Health Information Exchange
Level 1 Multi-Provider/Multi-Payer Consent

Please carefully read the information that follows before making your decision.

You may use this Consent Form to decide whether or not to allow Participating HEALTHeLINK Providers and Payers ("Participants") who are involved in your care to see and obtain access to your electronic health records for treatment and/or care management purposes. This form may be filled out now or at a later date. You can give consent or deny consent to some or all of the Participants. A complete list of Participants can be found at www.wnyhealthelink.com/Home/Patients/Participants. If you have any questions on completing this form go to www.wnyhealthelink.com/Home/Patients/PatientConsent. If you do not have internet access and would like a list of Participants or need help completing this form, please call (716)206-0993 ext 311. **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.**

In this Consent Form, you can choose whether to allow the Participants to obtain access to your medical records through a computer network operated by HEALTHeLINK, which is a part of a statewide healthcare computer network. This helps collect the medical records you have in different places where you get health care, and make them available electronically to the Participants rendering services to you.

SELECT ONLY ONE

☐ **YES** — **I GIVE CONSENT for all Participants who are involved in my care to access ALL of** my electronic health information through HEALTHeLINK. By checking this box you agree that, "Yes, the staff involved in my care including emergency care, quality improvement, care management, and pre-authorization activities at all the Participants may see and get access to all of my medical records through HEALTHeLINK."

☐ **YES EXCEPT** — **I GIVE CONSENT for all Participants who are involved in my care to access ALL** of my electronic health information through HEALTHeLINK except the following Participants:

Participant's Name **Participant's address or phone number**

These Participants cannot access my electronic health information via HEALTHeLINK *EXCEPT in a medical emergency*. If you have chosen to exclude any Participants, you **must** contact HEALTHeLINK at (716)206-0993 ext 311 to verify your form. If you wish to deny consent to additional Participants, please identify them on the Participant Exclusion Form and attach it to this form. You can find the form at www.wnyhealthelink.com/Home/Patients/PatientConsent. If you have attached the Participant Exclusion Form please check here ☐

☐ **NO EXCEPT** — **I DENY CONSENT for all Participants who are involved in my care to access** my electronic health information through HEALTHeLINK for any purpose, EXCEPT *in a medical emergency*. By checking this box you agree, "No, none of the Participants may be given access to my medical records through HEALTHeLINK unless it is a medical emergency."

☐ **NO NEVER** — **I DENY CONSENT for all Participants who are involved in my care to access** my electronic health information through HEALTHeLINK for any purpose, INCLUDING *in a medical emergency*.

NOTE: Unless you select "NO NEVER" 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 HEALTHeLINK.

PATIENT/LEGAL REPRESENTATIVE

Patient Last Name:

Patient First Name:

Patient Date of Birth: ☐ / ☐ / ☐ ☐ **Male** ☐ **Female**

Patient Address

City **State** **ZIP**

Signature of Patient or Patient's Legal Representative **Date of Signature**

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

WITNESS *

* If you are NOT completing this form in a Participant's office, you must have a witness complete the information below.

Print Name of Witness

Signature of Witness

Relationship of Witness to Patient (ex., spouse, son, neighbor, etc.)

HEALTHeLINK 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 a Participant for it, or go to the website www.ehealth4ny.org

Details about patient information in HEALTHeLINK and the consent process:

1. **How Your Information Will be Used.**
   Your electronic health information will be used by the Participating Providers you approve **only** to:
   - Provide you with medical treatment and related services
   - Check whether you have health insurance and what it covers.
   - Evaluate and improve the quality of medical care provided to all patients.

   Your electronic health information will be used by the Participating **Payers** you approve **only** for:
   - **Quality Improvement Activities.** These include evaluating and improving the quality of medical care provided to you and all of the health insurer's members.
   - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of health care 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.
   - **Pre-Authorization Activities.** These include reviewing and evaluating medical information in order to pre-approve services requested by you or your health care provider.

   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, 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
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Mental health conditions
   - Birth control and abortion (family planning)
   - 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 HEALTHeLINK. You can obtain an updated list at any time by checking the HEALTHeLINK website at www.wnyhealthelink.com or by calling 716-206-0993 ext. 311.

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 the medical staff of an approved Participating Provider who are involved in your medical care; health care providers who are covering or on call for an approved Participating Provider's doctors; and staff members of an approved Participants who carry out activities permitted by this Consent Form as described above in item one. A complete list of Participants is available from HEALTHeLINK at www.wnyhealthelink.com or by calling 716-206-0993 ext. 311.

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 www.wnyhealthelink.com; or call HEALTHeLINK at 716-206-0993 ext. 311; 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 the Participants 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 and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information. HEALTHeLINK and persons who access this information through the HEALTHeLINK must comply with these requirements.

7. **Effective Period**. This Consent Form will remain in effect until the day you withdraw your consent or HEALTHeLINK ceases to conduct business.

8. **Withdrawing Your Consent**. You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to one of the Participants. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms on HEALTHeLINK's website at www.wnyhealthelink.com or by calling 716-206-0993 ext. 311.

   Note: Organizations 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 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.