

**HEALTHIX CONSENT FORM**  
**[NAME OF PROVIDER ORGANIZATION/LOGO]**

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 Healthix, Inc., 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 Healthix, Inc.”

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 Healthix, Inc. for any purpose.”

Healthix, Inc. 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 Healthix 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 Healthix, Inc. 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 Healthix, Inc. 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 Healthix, Inc..**

If you want to deny consent for all Provider Organizations and Health Plans participating in Healthix to access your electronic health information through Healthix, you may do so by visiting Healthix’s website at [www.healthix.org](http://www.healthix.org) or by calling Healthix at 877-695-4749.

\_\_\_\_\_  
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 Healthix, Inc. 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
- Check whether you have health insurance and what it covers
- 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	HIV/AIDS
Birth control and abortion (family planning)	Mental health conditions
Genetic (inherited) diseases or tests	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 Healthix, Inc. You can obtain an updated list of Information Sources at any time by checking the Healthix, Inc.’s website at [www.healthix.org](http://www.healthix.org) or by calling 877-695-4749.

**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. Public Health and Organ Procurement Organization Access.** Federal, state and local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient’s consent for certain public health and organ transplant purposes. These entities may access your information through Healthix for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

**6. 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 Healthix, Inc.’s website: [www.healthix.org](http://www.healthix.org); 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/>.

**7. 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 and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information. Healthix, Inc. and persons who access this information through the Healthix, Inc. must comply with these requirements.

**8. Effective Period.** This Consent Form will remain in effect until the day you withdraw your consent or until such time as the RHIO ceases operation.

**9. Withdrawing Your Consent.** You can change your consent choices at any time by signing a new Consent Form and submitting it to [Name of Provider Organization]. You can get these forms on Healthix, Inc.’s website at [www.healthix.org](http://www.healthix.org), or by calling 877-695-4749. **Note: Organizations that access your health information through Healthix, Inc. 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.**

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