Healthix

One Time Authorization for Access to Minor Health Information Through a Health Information Exchange Organization

Patient Name	Date of Birth	Patient Identification No.

I choose to allow (Provider Name) _____ from [Name Organization], where I am receiving care today for medical services that, as a minor, I am legally authorized to consent to, to obtain access to my medical records through the health information exchange organization called **Healthix**. I understand that my medical records from different places where I get health care can be accessed just this one time so that my minor service provider can have the information needed to help give me the best care possible.

By signing below, I give consent for ONE TIME ONLY access to all my health information available in an electronic format through Healthix in order for the medical care provider to have access to my medical history and provide me with minor consented clinical services as needed.

Signature of Patient	Date
Print Name	

My questions about this form have been answered and I have been provided a copy of this form if requested.

Details about the information accessed through Healthix and the consent process:

1. **How Your Information May be Used**. Provider requesting this access will review your health information available in Healthix to help him/her with proper clinical assessment and design of a treatment plan for you. Electronic health information available through Healthix will be used **only** during this visit for **minor consented services** treatment.

2. **What Types of Information about You Are Included**. If you give consent, the Provider Organization listed in first paragraph may access ALL of your electronic health information available through **Healthix**. This includes information created before and after the date this form is signed. 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 include sensitive health conditions, including but not limited to:

   - Alcohol or drug use problems
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Mental health conditions
   - Sexually transmitted diseases
   - Employment Information
   - Living Situation
   - Social Supports
   - Medication and Dosages
   - Diagnostic Information
   - Allergies
   - Substance use history summaries
   - Clinical notes
   - Discharge summary
   - Claims Encounter Data
   - Lab Test

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from Healthix. You can obtain an updated list at any time by visiting Healthix's website at **www.healthix.org** or by calling 877-695-4749.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization you have given consent to access your information who carry out activities permitted by this form.

5. **Public Health and Organ Procurement Organization Access**. Federal, state or 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. This rule does not apply to clinical records relating to alcohol and drug use treatment.

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 Provider Organization at: ; or visit Healthix's website: 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 organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure**. Information about the services you have consented to receive may not be shared with your parents or guardians unless you want that information to be shared and you give your consent.**

8. **Effective Period**. This Consent Form will remain in effect **ONLY** for the duration of minor consented services treatment received on the date signed.

9. **Copy of Form**. You are entitled to get a copy of this Consent Form**.**