Upstate Family Health Center, Inc.

HealtheConnections®

**Authorization for Access to Patient Information**
New York State Department of Health
**Through a Health Information Exchange Organization**

| Patient Name | Date of Birth |
|---|---|
| Other Names Used (e.g., Maiden Name): | |

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow the Organization named above to obtain access to my medical records through the health information exchange organization called HealtheConnections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network.

HealtheConnections is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit the HealtheConnections website at http://healtheconnections.org/ .

**My choice in this form will NOT affect my ability to get medical care. My choice in this form does NOT allow health insurers to access my information to decide whether to provide me with health insurance coverage or pay my medical bills.**

| **My Consent Choice**. ONE box is checked to the left of my choice.<br>I can fill out this form now or in the future.<br>I can also change my decision at any time by completing a new form. |
|---|
| ☐ **1. I GIVE CONSENT** for the Organization named above to access ALL of my electronic health information through HealtheConnections to provide health care services (including emergency care). |
| ☐ **2. I DENY CONSENT** for the Organization named above to access my electronic health information through HealtheConnections for any purpose, ***even*** *in a medical emergency*. |

If I want to deny consent for all Provider Organizations and Health Plans participating in HealtheConnections to access my electronic health information through HealtheConnections, I may do so by visiting HealtheConnections website at http://healtheconnections.org/ or calling HealtheConnections at 315.671.2241 x5.

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

| Signature of Patient or Patient's Legal Representative | Date |
|---|---|
| Print Name of Legal Representative (if applicable) | Relationship of Legal Representative to Patient (if applicable) |