



**Authorization for Access to Patient Information
Through a Health Information Exchange Organization**

New York State Department of Health

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 **Clifton Fine Healthcare Corporation** to obtain access to my medical records through the health information exchange organization called Health_eConnections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Health_eConnections 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 Health_eConnections website at <http://healthconnections.org/>.

My information may be accessed in the event of an emergency, unless I complete this form and check box #3, which states that I deny consent *even* in a medical emergency.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

<p>My Consent Choice. ONE box is checked to the left of my choice. I can fill out this form now or in the future. I can also change my decision at any time by completing a new form.</p>
<p><input type="checkbox"/> 1. I GIVE CONSENT for Clifton Fine Healthcare Corporation to access ALL of my electronic health information through Health_eConnections to provide health care services (including emergency care).</p>
<p><input type="checkbox"/> 2. I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY for Clifton Fine Healthcare Corporation to access my electronic health information through Health_eConnections.</p>
<p><input type="checkbox"/> 3. I DENY CONSENT for Clifton Fine Healthcare Corporation to access my electronic health information through Health_eConnections for any purpose, <i>even in a medical emergency</i>.</p>

If I want to deny consent for all Provider Organizations and Health Plans participating in Health_eConnections to access my electronic health information through Health_eConnections, I may do so by visiting Health_eConnections website at <http://healthconnections.org/> or calling Health_eConnections 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 <u>04/02/18</u>
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

