



# Colon Rectal Associates of CNY LLP

New York State Department of Health

## Authorization for Access to Patient Information 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 HealthConnections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. HealthConnections 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 HealthConnections website at <http://healthconnections.org/>.

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.

|                                                                                                                                                                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>My Consent Choice.</b> 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.                            |
| <input type="checkbox"/> <b>1. I GIVE CONSENT</b> for the Organization named above to access ALL of my electronic health information through HealthConnections to provide health care services (including emergency care). |
| <input type="checkbox"/> <b>2. I DENY CONSENT</b> for the Organization named above to access my electronic health information through HealthConnections for any purpose, <i>even in a medical emergency</i> .              |

If I want to deny consent for all Provider Organizations and Health Plans participating in HealthConnections to access my electronic health information through HealthConnections, I may do so by visiting HealthConnections website at <http://healthconnections.org/> or calling HealthConnections 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) |