



Hixny Electronic Data Access Consent Form [Name of Organization]

In this Consent Form, you can choose whether to allow [Name of Organization] to obtain access to your medical records through a computer network operated by the Healthcare Information Xchange of New York (Hixny), 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 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 Organization] staff involved in my care may see and get access to all of my medical records through Hixny.”

If you check the “**I DENY CONSENT**” box below, you are saying “No, [Name of Organization] may not be given access to my medical records through Hixny for any purpose.”

Hixny is a not-for-profit organization. It shares information about people’s health electronically and securely to improve the quality of health care services.

Please carefully read the information on both pages of this form before making your decision.

You have two choices:

- I GIVE CONSENT for [Name of Organization] to access ALL of my medical records through Hixny in connection with providing me any health care services, including emergency care.**
- I DENY CONSENT for [Name of Organization] to access my medical records through Hixny for any purpose, *even in a medical emergency.* Unless you check this box, New York State law allows medical providers treating you in an emergency to get access to your medical records, including records that are available through Hixny.**

Print Name of Patient

Date of Birth

Date

Signature of Patient or Patient’s Legal Representative

Print Name of Legal Representative (if applicable)

Relationship of Legal Representative to Patient (if applicable)

Details about patient information in Hixny and the consent process:

How Your Information Will Be Used

Your electronic health information will be used by [Name of 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

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.

What Types of Information About You Are Included

If you give consent, Northeast FNP's may access ALL of your electronic health information available through Hixny. 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*
- Birth control and abortion (family planning)
- Genetic (inherited) diseases or tests
- HIV/AIDS
- Mental health conditions
- Sexually transmitted diseases

***If you have received alcohol or drug abuse care, your record may include information related to your alcohol or drug abuse diagnoses, such as medications and dosages, lab test results, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social support, and health insurance claims history.**

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 Hixny. You can obtain an updated list of Information Sources at any time by checking the Hixny website: www.hixny.org.

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 Organization] medical staff who are involved in your medical care; health care providers who are covering or on call for [Name of Organization]'s doctors; and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

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 Organization] at: [redacted]; or call Hixny at (518) 640-0021; or call the NYS Department of Health at 518-474-4987.

Re-disclosure of Information

Any electronic health information about you may be re-disclosed by [Name of 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. Hixny and persons who access this information through the Hixny must comply with these requirements.

Effective Period

This Consent Form will remain in effect until the day you withdraw your consent or until such time Hixny ceases operation.

Withdrawing Your Consent

You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to [Name of Organization]'s. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms from any Hixny provider, from the Hixny website at www.hixny.org, or by calling (518) 640-0021.

NOTE: Organizations that access your health information through Hixny 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.

Copy of Form

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

Withdrawal of Consent

I have previously signed a Patient Consent Form that granted [organization name] access to my medical information through Healthcare Information Xchange of New York (“Hixny”). At this time, I no longer want [organization name] to have access to my medical information through Hixny.

1. This Withdrawal of Consent applies to [organization name] only. I understand that if I wish to withdraw my consent granting other Hixny organizations that participate in my treatment access to my medical information, I must do so by contacting these other Hixny Participants directly.
2. I understand that, by checking the box below, I am denying [organization name] the right to access my medical information:
 I do not wish my medical information to be available to [organization name]
3. I understand that this Withdrawal of Consent will not affect or undo any exchange of my medical information that occurred while my original consent was in effect.
4. I understand that my withdrawal of consent for [organization name] does not affect any consent(s) that I may have previously given to other Hixny Participant(s). These will remain in effect until I specifically withdraw them by contacting these other Hixny Participants directly.
5. I understand that it may take several days to process this Withdrawal of Consent.
6. I understand that no Hixny Participant can deny me medical care as a result of this Withdrawal of Consent. I also understand that my health insurance eligibility cannot be affected by this Withdrawal of Consent.

Print Name of Patient

Patient’s Date of Birth

Signature of Patient/Patient’s Representative
(if patient is unable to sign)

Date

Print Name of Patient’s Representative

Relationship of Patient’s Representative