HEALTHeLINK Authorization for Access to Patient Information Through HEALTHeLINK

Patient First Name

Patient Last Name

Date of Birth M M / D D / Y Y Y Y

Patient Address

Street _____ Apartment _____

City _____, State _____ Postal Code _____

Gender

☐ Male ☐ Female

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 Participating HEALTHeLINK Providers and Payers ("Participants") who are involved in my care to obtain access to my medical records through the health information exchange organization called HEALTHeLINK. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. HEALTHeLINK 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 HEALTHeLINK's website at www.wnyhealthelink.com.

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.

SELECT ONLY ONE

My Consent Choice. Only 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.

☐ **1. YES**	**I GIVE CONSENT** to all current and future Participants, who are involved in my care, to access ALL of my electronic health information through HEALTHeLINK.
☐ **2. YES, EXCEPT SPECIFIC PARTICIPANT(S)**	**I GIVE CONSENT** to all current and future Participants, who are involved in my care, to access ALL of my electronic health information through HEALTHeLINK, **EXCEPT** the Participant(s) listed below. Participant's Name (Provider Office): / Participant's address or phone number:
☐ **3. YES, ONLY SPECIFIC PARTICIPANT(S)**	**I GIVE CONSENT ONLY** to the specific Participant(s) listed below to access ALL of my electronic health information through HEALTHeLINK. Participant's Name (Provider Office): / Participant's address or phone number:
☐ **4. NO, EXCEPT IN AN EMERGENCY**	**I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY** for current and future Participants to access my electronic health information through HEALTHeLINK.
☐ **5. NO, EVEN IN AN EMERGENCY**	**I DENY CONSENT** for current and future Participants to access my electronic health information through HEALTHeLINK for any purpose, ***even*** in a medical emergency.

I understand that my information may be accessed in the event of an emergency, unless I complete this form and check box #5, which states that I deny consent *even* in a medical emergency.

I understand that upon my request, HEALTHeLINK is required to provide me with a list of disclosures of my electronic health information under the terms of this form.

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

Signature of Patient or Patient's Legal Representative

X_____

Date of Signature M M / D D / Y Y Y Y

Print Name of Patient's Legal Representative (if applicable)

Relationship of Legal Representative to Patient (if applicable)

☐ Parent ☐ Healthcare agent/proxy

☐ Guardian ☐ Other_____

This Box To Be Filled Out Only By The Provider

_____

Entity Consent Received By

Witness*

*Required if NOT completing this form in a Participant's office.

_____ Print Name of Witness

_____ Signature of Witness

_____ Relationship of Witness to Patient (ex., spouse, son, neighbor, etc.)