



Hematology/Oncology Associates of Central New York

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 **Hematology/Oncology Associates of Central New York** 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/>.

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 Hematology/Oncology Associates of Central New York to access ALL of my electronic health information through HealthConnections to provide health care services (including emergency care).</p>
<p><input type="checkbox"/> 2. I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY for Hematology/Oncology Associates of Central New York to access my electronic health information through HealthConnections.</p>
<p><input type="checkbox"/> 3. I DENY CONSENT for Hematology/Oncology Associates of Central New York to access my electronic health information through HealthConnections 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 **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)

Details about the information accessed through Health_eConnections and the consent process:

1. **How Your Information May be Used.** Your electronic health information will be used **only** for the following healthcare services:
 - **Treatment Services.** Provide you with medical treatment and related services.
 - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
 - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
 - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.
2. **What Types of Information about You Are Included.** If you give consent, the Provider Organization and/or Health Plan listed may access ALL of your electronic health information available through Health_eConnections. This includes information created before and after the date this form is signed. 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 include 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
3. **Where Health Information About You Comes From.** Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from Health_eConnections. You can obtain an updated list at any time by checking Health_eConnections website at <http://healthconnections.org/> or by calling 315.671.2241 x5.
4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one.
5. **Public Health and Organ Procurement Organization Access.** Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through Health_eConnections for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.
6. **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 the Provider Organization at: **315-472-7504 x1312**; or visit Health_eConnections website at <http://healthconnections.org/>; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: <http://www.hhs.gov/ocr/privacy/hipaa/complaints/>.
7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.
8. **Effective Period.** This Consent Form will remain in effect until the day you change your consent choice or until such time as Health_eConnections ceases operation. If Health_eConnections merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.
9. **Changing Your Consent Choice.** You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice. Organizations that access your health information through Health_eConnections while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.
10. **Copy of Form.** You are entitled to get a copy of this Consent Form.