Patient Consent to Participate in HEALTHeLINK Health Information Exchange

I understand that if I give Consent below, I am allowing Western New York Clinical Information Exchange ("HEALTHeLINK") to release and provide access to all of my Medical Information to my health care providers and health insurers who are treating me, that I am enrolled with, or that are making payments for my health care and are participating now or in the future in HEALTHeLINK. If I sign this form as the Patient's Legal Representative, I understand that all references in this form to "me" or "my" refer to the Patient.

1. **Purpose:** I understand that my Medical Information disclosed to HEALTHeLINK will be used only to provide me with medical treatment and to assess and improve the quality of medical care delivered by my health care providers.
2. **Types of Information:** I understand that this Consent permits access to **all** of my available Medical Information, including but not limited to, sensitive information related to the following:
   - HIV/AIDS
   - Genetic Disease or Genetic Tests
   - Sexually Transmitted Diseases
   - Mental Health
   - Alcohol or Drug Abuse Treatment
   - Family Planning/Reproductive Care
3. **Electronic Health Information Sources:** Information accessed through HEALTHeLINK comes from a variety of sources ("Electronic Health Information Sources"). These Electronic Health Information Sources may include participating providers, other health care providers (such as pharmacies and clinical laboratories), health insurers, the New York State Medicaid program and other health information exchanges. A complete list of current Electronic Health Information Sources may be found at www.wnyhealthelink.com. This list will change from time-to-time as HEALTHeLINK continues to grow.
4. This Consent permits access to Medical Information created both before and after the date I sign this form. I understand that information about me may be re-disclosed only to the extent permitted by applicable laws and regulations. I understand that if I give consent, my consent will remain in effect until the day I withdraw consent or HEALTHeLINK stops operating, whichever comes first.
5. I understand that Health Insurers will have access to Medical Information for Disease Management, Case Management and Quality Improvement purposes. Health Insurers will not use this information for claim or coverage determination.
6. I understand that if I change my mind and wish to withdraw consent, I can sign a Withdrawal of Consent form. If I withdraw consent, access will no longer be available to Medical Information about me through HEALTHeLINK unless and until I again give consent by signing and completing a new Consent form. The withdrawal of consent will not affect the exchange of my Medical Information made while my Consent was in effect.
7. I understand that if I Deny Consent below, there will be no access to my Medical Information through HEALTHeLINK, except in an emergency.
8. I understand that the decision to participate in HEALTHeLINK is voluntary. No participating HEALTHeLINK health care provider will deny me medical care and my insurance eligibility will not be affected if I Deny Consent to participate.
9. I understand that I can access a list of participating HEALTHeLINK health care providers and health insurers by either going to www.wnyhealthelink.com or by calling 716-206-0993 to have the most current list of providers sent to me either by fax or mail.
10. I understand that de-identified data (no one will be able to identify me personally) may be used by HEALTHeLINK for research and evaluation purposes.
11. I understand that I will get a copy of this form after I sign it.

I hereby: ☐ Give Consent; or ☐ Deny Consent (Check One Box Only)

_____
Entity Consent Received By

_____ **Printed Name of Patient** **Date of Birth**	_____ **Signature of Minor (if between the ages of 12 and 18)** **Date**
_____ **Signature of Patient or Patient's Legal Representative** **Date**	_____ **Print Name of Patient's Legal Representative (if applicable)**
_____ **Address/City/State/Zip Code of Patient**	_____ **Authority to sign on behalf of patient (e.g., health care agent, guardian, parent)**

If you are NOT completing this form in a provider's office, you must have a witness complete the information below:

_____ **Printed Name of Witness**	_____ **Relationship of Witness to Patient (e.g., spouse, son, neighbor)**
_____ **Signature of Witness** **Date**	