HealthlinkNY Health Information Exchange
LEVEL ONE HEALTH INFORMATION EXCHANGE CONSENT FORM

ORGANIZATION: Choices Mental Health Counseling, PLLC

I understand that I can choose whether to allow the Provider Organization or Health Plan named above to obtain access to my medical records through a computer network operated by HealthlinkNY, which is part of a statewide computer network. This can help collect my medical records from different places where I receive health care. HealthlinkNY is a not-for-profit organization that electronically shares information about people's health and meets the privacy and security standards of HIPAA and New York State Law. To learn more, visit the HealthlinkNY website at www.healthlinkny.com.

Your choice will not affect your ability to receive medical care or obtain health insurance coverage. Your choice to give or deny consent may not be used as the basis for denial of health services. The choice you make on 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.

Before making your decision, please carefully read the Consent Form Information Sheet about how your information is used.

Your Consent Choices. You can fill out this form now or in the future. You can also change your decision at any time by completing a new form. This form must be filled out completely to be valid.

Please choose only one of the following two options:

☐ **I GIVE CONSENT** for the Provider Organization or Health Plan named above to access ALL of my electronic health information through HealthlinkNY in connection with providing me health care services, including emergency care.

☐ **I DENY CONSENT** for the Provider Organization or Health Plan named above to access my electronic health information through HealthlinkNY for any purpose, ***even in a medical emergency.***

If you want to deny consent for all Provider Organizations and Health Plans participating in HealthlinkNY, you may do so by visiting www.healthlinkny.com or calling 844-840-0050.

Printed First Name of Patient | Printed Last Name of Patient | Patient Date of Birth (MM / DD / YYYY)

Signature of Patient | Date of Signature (MM / DD / YYYY)

---------- *This section below is to be completed by the Patient's Legal Representative (if applicable)* ----------

Printed First Name of Legal Representative | Printed Last Name of Legal Representative | Relationship of Legal Representative

Legal Representative Signature | Date of Legal Representative Signature (MM / DD / YYYY)

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HealthlinkNY
Health Information Exchange

CONSENT FORM INFORMATION SHEET

Details about patient information in HealthlinkNY and the consent process

1. How will your information 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 will be available? If you give consent, the Provider Organization or Health Plan named on the form may access ALL of your electronic health information available through HealthlinkNY. 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
- HIV/AIDS
- Mental health conditions
- Genetic (inherited) diseases or tests
- Sexually transmitted diseases
- Birth control and abortion (family planning)

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

3. Where does your health information come 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 list of current information sources is available on the HealthlinkNY website at www.healthlinkny.com or by calling 844-840-0050.

4. Who may access your information if you give consent? Only authorized providers, other staff members, and affiliated practitioners of the Provider Organization or Health Plan named on the form who carry out activities permitted by this Consent Form as described above in paragraph one.

5. Public Health and Organ Procurement Organization Access. Because 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 HealthlinkNY for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. Are there 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 you suspect that your records have been accessed by someone not authorized to do so, contact HealthlinkNY for an access audit at info@healthlinkny.com or 844-840-0050; or if you prefer to contact your Provider Organization or Health Plan directly, you can access their contact information on the HealthlinkNY website at: www.healthlinkny.com/participating-providers-pg.html; or the NYS Department of Health at 518-474-4987; or follow the complaint process at the following HHS Office for Civil Rights link: http://www.hhs.gov/ocr/privacy/hipaa/complaints/.

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7. Is re-disclosure of my information permitted? Any electronic health information about you may be re-disclosed by the Participating Organization or Health Plan named on the form 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 paper form. Some state and federal laws provide special protections for certain kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment, and special requirements must be followed whenever this kind of sensitive health information is disclosed. The Participating Organization or Health Plan named on the form and persons who access this information through HealthlinkNY must comply with these requirements.

8. How long will your consent be in effect? This Consent Form will remain in effect until the day you change your consent choice or until such time HealthlinkNY ceases operation ***(or until 50 years after your death whichever occurs first)***. If HealthlinkNY merges with another Qualified Entity your consent choices will remain in effect with the newly merged entity.

9. How do you update or withdraw your consent? You can change your consent choice at any time for any Participating Organization or Health Plan by submitting a new Consent Form with your new choice.

Note: Organizations that access your health information through HealthlinkNY, 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, they are not required to return it or remove it from their records.

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

THIS FORM MEETS ALL REQUIREMENTS OF THE FEDERAL CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS (42 C.F.R. PART 2), THE NEW YORK STATE DEPARTMENT OF HEALTH PUBLIC HEALTH LAW 18 AND THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) (45 C.F.R PARTS 160 AND 164).