Cayuga Area Plan, Inc.
Cayuga Area Preferred, Inc.

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Health eConnections

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Authorization for Access to Patient Information Through a Health Information Exchange Organization

New York State Department of Health

Patient Name:	Other Names Used (e.g., Maiden Name):	Date of Birth:

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 Cayuga Area Plan, Inc ("CAP") and the physicians, physician practices, and hospitals participating in CAP (see http://www.CAPNY.com for full list) to obtain access to my medical records through the health information exchange organization called HealtheConnections. If I give consent, my medical records from different places where I get health care, can be accessed using a statewide computer network. HealtheConnections 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 HealtheConnections website at http://healtheconnections.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.

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.

☑ 1. **I GIVE CONSENT** for Cayuga Area Plan, Inc ("CAP") and the physicians, physician practices, and hospitals participating in CAP (see http://www.CAPNY.com for full list) to access ALL of my electronic health information through HealtheConnections to provide health care services (including emergency care).

☐ 2. **I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY** for Cayuga Area Plan, Inc ("CAP") and the physicians, physician practices, and hospitals participating in CAP (see http://www.CAPNY.com for full list) to access my electronic health information through HealtheConnections.

☐ 3. **I DENY CONSENT** for Cayuga Area Plan,Inc ("CAP") and the physicians, physician practices, and hospitals participating in CAP (see http://www.CAPNY.com for full list) through HealtheConnections for any purpose, *even in a medical emergency*.

If I want to deny consent for all Provider Organizations and Health Plans participating in HealtheConnections to access my electronic health information through HealtheConnections, I may do so by visiting HealtheConnections website at http://healtheconnections.org or calling HealtheConnections at 315.671.2241 x5.

My questions about this form have been answered and I have been provided with a copy of this form.

Signature of Patient or Patient's Legal Representative: Bonze Blayk	Date: 11/15/18
Print Name of Legal Representative (if applicable):	Relationship of Legal Representative to Patient (if applicable):

Details about the information accessed through HealtheConnections 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 HealtheConnections . 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 HealtheConnections. You can obtain an updated list at any time by checking HealtheConnections website at http://healtheconnections.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 throug HealtheConnections 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: **(607) 274-4316**; or visit HealtheConnections website at http://healtheconnections.org; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office of 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 HealtheConnections ceases operation. If HealtheConnections 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 HealtheConnections 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.

Record limit (1) reached.