

Catania Chiropractic PC

Health Connections

New York State Department of Health

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

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 the Organization named above to obtain access to my medical records through the health information exchange organization called Health Connections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Health Connections 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 Health Connections website at <http://healthconnections.org/>.

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>
<input type="checkbox"/> 1. I GIVE CONSENT for the Organization named above to access ALL of my electronic health information through Health Connections to provide health care services (including emergency care).
<input type="checkbox"/> 2. I DENY CONSENT for the Organization named above to access my electronic health information through Health Connections for any purpose, even in a medical emergency.

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