WMC Health | HealthAlliance
Westchester Medical Center Health Network

Authorization for Access to Patient Information Through Health Information Exchange Organizations

Name	Date of Birth	Identification Number
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 employees, agents, or members of the medical staff of the Provider Organizations of WMCHealth * to obtain access to my medical records through the following participating health information exchange organizations: HealtheConnections and Hixny. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network called the SHIN-NY. HealtheConnections and Hixny are not-for-profit organizations that share information about people's health electronically and meet the privacy and security standards of HIPAA and New York State Law. To learn more, visit these websites:

www.healtheconnections.org
www.hixny.org
https://www.nyehealth.org/shin-ny/what-is-the-shin-ny/

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 bills. You can make that choice in a separate Consent Form that health insurers must use.

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.	
☐	I GIVE CONSENT for WMCHealth to access ALL of my electronic health information through the SHIN-NY to provide health care services (including emergency care).
☐	I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY for WMCHealth to access my electronic health information through the SHIN-NY.
☐	I DENY CONSENT for WMCHealth to access my electronic health information through the SHIN-NY for any purpose, even in a medical emergency (except for minor patients). Unless you check this box, New York State law allows medical providers treating you in an emergency to get access to your medical records, including records that are available through the SHIN-NY.

If I want to deny consent for all Provider Organizations and Health Plans participating in the Statewide Health Information Network for New York (SHIN-NY) that access my electronic health information through one of the following HIEs, I may do so by contacting each of the HIEs individually:

HealtheConnections	www.healtheconnections.org	315-671-2241 x 5
Hixny	www.hixny.org	518-640-0021

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	Date of Birth
Print Name of Patient or Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)	

Details about the information accessed through the SHIN-NY 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. I**f you give consent, WMCHealth may access ALL of your electronic health information available through the SHIN-NY. This includes information created before and after the date this form is signed. Your health records may include clinical notes, discharge summaries, allergies, a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), treatments you have received, your diagnoses, and lists of medicines you have taken. These records may contain all of this information about 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

   ** 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 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 WMCHealth, HealtheConnections, and/or Hixny. You can obtain an updated list at any time by checking the websites of the participating organizations or calling them at the numbers on this form.
4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of WMCHealth who carry out activities permitted by this form as described above in paragraph one. If there is an emergency, doctors and other staff members will be able to use the SHIN-NY to see the health information of patients who are minors.
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 the SHIN-NY 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 WMCHealth at 914-493-2600; or visit the websites of HealtheConnections or Hixny; 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. This is also true for health information about you that exists in paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. 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 withdraw or change your consent choice or until such time as WMCHealth, HealtheConnections or Hixny cease operations (or until 50 years after your death whichever occurs first). If HealtheConnections or Hixny merge 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(s) or submitting a Withdrawal of Consent Form to WMCHealth. Organizations that access your health information through the SHIN-NY 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.

*Definition. By signing this consent form, you are permitting the providers, employees, agents and members of the Medical Staffs of each of the provider entities below affiliated with WMCHealth to access your records through the SHIN-NY. More information on WMCHealth locations is available at: https://www.wmchealth.org/contact-us

- Westchester Medical Center including:
  Maria Fareri Children's Hospital
  Behavioral Health Center
- MidHudson Regional Hospital
- Good Samaritan Hospital of Suffern, N.Y.
- St. Anthony Community Hospital, Warwick, New York
- Bon Secours Community Hospital
- St. Francis at the Knolls (Mt. Alverno Center)
- Villa Frances at the Knolls (Schervier Pavilion)
- HealthAlliance Hospital
- Margaretville Hospital
- Mountainside Residential Care Center
- Westchester Medical Center Advanced Physician Services, P.C.
- Bon Secours Charity Health System Medical Group, P.C.
- North Road LHCSA

OFFICE USE ONLY:

☐ Patient is unable to provide consent due to condition

☐ Patient refused to sign

_____ _____

Hospital Staff Person's Name Date & Time