

Patient Consent Form for Participating Provider Organization

_____ (Name of Participating Provider Organization)

I have received the document entitled “Brooklyn Health Information Exchange: Educational Fact Sheet” which explains how the Brooklyn Health Information Exchange (“BHIX”) works, how it operates, and how I can allow medical information about me to be accessed by the hospitals, nursing homes, home health agencies and other health care providers participating in BHIX. 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.

Each Participating Provider Organization (“Participating Provider”) involved in my care must obtain my Consent separately to access my medical information through BHIX. _____ is a Participating Provider in BHIX. I understand that if I Give Consent below, I hereby authorize _____, including all individuals authorized by _____ to use BHIX, to access my medical information through BHIX.

1. **Purpose:** I understand that my medical information will be used only to provide me with medical treatment and to assess and improve the quality of medical care delivered by _____ to its patients.
2. **Types of Information:** I understand that this Consent permits _____ to access ALL of my 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
3. **Health Information Sources:** Information accessed through BHIX comes from a variety of sources (“Health Information Sources”). These 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 Health Information Sources may be found at www.bhix.org. This list will change from time-to-time as BHIX continues to grow.
4. This Consent permits _____ to access medical information created both before and after the date I sign this form. I understand that information about me may be re-disclosed by _____ 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 BHIX stops operating, whichever comes first.
5. 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, _____ will no longer be able to routinely access medical information about me through BHIX unless and until I again Give Consent by signing and completing a new Patient Consent Form. The withdrawal of consent will not affect the exchange of medical information made while my Consent was in effect.
6. I understand that if I Deny Consent below, _____ will not access medical information through BHIX —*even in an emergency*.
7. I understand that the decision to participate in BHIX is voluntary. No Participating Provider will deny me medical care and my insurance eligibility will not be affected if I Deny Consent to participate in BHIX.
8. I understand I will get a copy of this form after I sign it.

I hereby: Give Consent Deny Consent

for _____ to access ALL of my medical information from all Health Information Sources through BHIX.

Print Name of Patient	Patient’s Date of Birth
Signature of Patient or Patient’s Legal Representative	Date
Print Name of Patient’s Legal Representative (if applicable)	Relationship of Patient’s Legal Representative