

HealthlinkNY Health Information Exchange LEVEL ONE HEALTH INFORMATION EXCHANGE CONSENT FORM

ORGANIZATION:	Boston Children's Health Physicians, LLP						
access to my medical records the statewide computer network. The health care. HealthlinkNY is a result of the statement of th	whether to allow the Provider Organization or Health Plan named above to obtain a computer network operated by HealthlinkNY, which is part of a nis can help collect my medical records from different places where I receive not-for-profit organization that electronically shares information about people's not security standards of HIPAA and New York State Law. To learn more, visit the ealthlinkny.com.						
choice to give or deny conser make on this Consent Form d	ur ability to receive medical care or obtain health insurance coverage. Your not may not be used as the basis for denial of health services. The choice you oes NOT allow health insurers to have access to your information for the to give you health insurance or pay your bills.						
Before making your decision, information is used.	please carefully read the Consent Form Information Sheet about how your						
	an fill out this form now or in the future. You can also change your decision at orm. This form must be filled out completely to be valid.						
Please choose only one of the	e 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.							
	T for the Provider Organization or Health Plan named above to access my electronic through HealthlinkNY for any purpose, <i>even in a medical emergency.</i>						
If you want to deny consent for all Provider C calling 844-840-0050.	Organizations and Health Plans participating in HealthlinkNY, you may do so by visiting www.healthlinkny.com or						
Printed First Name of Patient	Printed Last Name of Patient Patient Date of Birth (MM / DD / YYYY)						
Signature of Patient	Date of Signature						

HealthlinkNY • (844) 840-0050 • www.healthlinkny.com 49 Court Street, Suite 300 • Binghamton, New York 13901 300 Westage Business Center Drive, Suite 150 • Fishkill, NY 12524

(MM / DD / YYYY) This section below is to be completed by the Patient's Legal Representative (if applicable)-

Printed Last Name of Legal Representative

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

Relationship of Legal Representative

Printed First Name of Legal Representative

Legal Representative Signature