



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



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

New York State Department of Health

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 Cayuga Area Plan, Inc (CAP) and the physicians and physician practices participating in the Cayuga Area Physicians Alliance, Inc.(see <http://cayugaareaphysiciansalliance.org> for full list) to obtain access to my medical records through the health information exchange organization called HealtheConnections, and any viewer or portal displaying data supplied by 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 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 and physician practices participating in the Cayuga Area Physicians Alliance, Inc.** 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 and physician practices participating in the Cayuga Area Physicians Alliance, Inc.** to access my electronic health information through HealtheConnections.
- 3. **I DENY CONSENT for Cayuga Area Plan, Inc (CAP) and the physicians and physician practices participating in the Cayuga Area Physicians Alliance, Inc.** to access my electronic health information 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 a copy of this form.

FORM TO BE ELECTRONICALLY SIGNED DURING PATIENT REGISTRATION

DOH-(6/14)

Clinical Integration Privacy Notice & Consent Form

We are pleased to be part of the Cayuga Area Preferred ("CAP") Clinical Integration Program. Clinical Integration is intended to improve the safety, efficiency, and quality of health care by allowing all health care providers participating in the CAP Clinical Integration Program to have access to and share data in your medical record in order to provide care to you and for purposes of improving the quality of care in the community. To learn more about Clinical Integration please talk to your physician. You can also call CAP at (607)252-3694.

Providers participating in the Clinical Integration Program are able to access protected health information (PHI) about you collected or accessible from all places where you get health care and from the insurance companies that pay for your health care. This information is only to be used in connection with providing care to you and for purposes of improving the quality of care in the community and is only open to providers participating in the CAP Clinical Integration Program and their staffs. You may decide whether or not to allow CAP participating providers and their staffs to access your protected health information. **Your choice to give or deny consent will not affect your ability to get medical care or health insurance coverage and will not be the basis for denial of health services.**

Furthermore, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you have certain rights to privacy regarding protected health information. A description of those rights together with the purposes for which your protected health information may be used or disclosed is set forth in this provider's Notice of Privacy Practices, a copy of which has been provided to you.

If you sign this form, you may request, in writing, restrictions on how your protected health information is used or disclosed to carry out treatment, payment or healthcare operations within the network of providers participating in the CAP Clinical Integration Program. Please carefully read the information on the back of this form before making your decision.

By signing this form, you give consent for purposes of providing care to you for all providers participating in the CAP Clinical integration Program and their staffs to access ALL of your protected health information available through a database maintained by CAP and from other sources made available to CAP participating providers, including the electronic medical system of Cayuga Medical Center (together, this information is hereinafter referred to as the "Cap Database"). You further acknowledge that you have received this provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of your protected health information.

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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 patients consent for certain public health and organ transplant purposes. These entities may access your information through 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: 607.274.4615 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 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. 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 HealthConnections ceases operation. If HealthConnections 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 HealthConnections 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.

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Cayuga Medical Associates, PC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.