healthlinkny
Your link to Statewide Health Information

HealthlinkNY Health Information Exchange
LEVEL ONE HEALTH INFORMATION EXCHANGE CONSENT FORM

ORGANIZATION: Boston Children's Health Physicians, LLP

I understand that I can choose whether to allow the Provider Organization or Health Plan named above to obtain access to my medical records through a computer network operated by HealthlinkNY, which is part of a statewide computer network. This can help collect my medical records from different places where I receive health care. HealthlinkNY is a not-for-profit organization that electronically shares information about people's health and meets the privacy and security standards of HIPAA and New York State Law. To learn more, visit the HealthlinkNY website at www.healthlinkny.com.

Your choice will not affect your ability to receive medical care or obtain health insurance coverage. Your choice to give or deny consent may not be used as the basis for denial of health services. The choice you make on this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills.

Before making your decision, please carefully read the Consent Form Information Sheet about how your information is used.

Your Consent Choices. You can fill out this form now or in the future. You can also change your decision at any time by completing a new form. This form must be filled out completely to be valid.

Please choose only one of the 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.

☐ **I DENY CONSENT** for the Provider Organization or Health Plan named above to access my electronic health information through HealthlinkNY for any purpose, ***even in a medical emergency.***

If you want to deny consent for all Provider Organizations and Health Plans participating in HealthlinkNY, you may do so by visiting www.healthlinkny.com or calling 844-840-0050.

Printed First Name of Patient | Printed Last Name of Patient | Patient Date of Birth (MM / DD / YYYY)

Signature of Patient | Date of Signature (MM / DD / YYYY)

---------- *This section below is to be completed by the Patient's Legal Representative (if applicable)* ----------

Printed First Name of Legal Representative | Printed Last Name of Legal Representative | Relationship of Legal Representative

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

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