Patient Denial of Consent to All Healthix Participating Organizations

What You Should Know Before Signing This Form

Healthix is a non-for-profit Qualified Entity (QE) certified by the NYS Department of Health to participate in the State Health Information Network of New York (SHIN-NY, devoted to developing, deploying and operating innovative uses of interoperable health information technology and analytics to facilitate patient-centric care and promote improved health care quality, affordability and outcomes for New Yorkers.

I understand that I have the right to grant or deny access to my protected health information via the Healthix. **I understand that Denial of Consent to All Healthix Participating Providers means my healthcare providers, insurers or other organizations participating in Healthix will not have access to my protected health information via Healthix.** To have this request processed**, please have this form notarized** and returned via email to compliance@healthix.org

To reinstate access in the future I can file a new authorization form with the Healthix participant to whom I wish to grant consent.

By denying my consent, I understand that:

1. Healthcare providers and health insurers that are providing services to me will not be able to access my medical information about me through Healthix, **even in an emergency.**

2. My Denial of Consent will not affect the exchange of my medical information that occurred prior to this "Deny All" notice being recorded by Healhtix.

3. No Healthix participating provider will deny me medical care and my insurance eligibility will not be affected based on my Denial of Consent.

4. My Denial of Consent does not prevent my health care providers from submitting claims to my health insurer for reimbursement for services rendered to me.

5. Public Health agencies will remain eligible to access my clinical data in accordance with applicable NYS public health laws.

6. I understand that I will get a copy of this form after I sign it.

_____ _____

Patient Name Patient Date of Birth

_____ _____

Patient Signature Date of Signature

_____

Patient Address/ City/ State/ Zip Code

Print Name of Patient's Legal Representative (if applicable) **signing on behalf of patient:**

_____ _____

Signature of Date of Signature

_____

Legal Representative Relationship to the Patient (e.g., parent, legal guardian)