Updated 11/2021

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**,** we will need to validate your identity. This can be accomplished through (a) an on-line video meeting where you show government issued identification (e.g., a driver's license); (b) a notary confirming your identity on this form; or (c) confirmation of unique information in your file such as your address and date of birth. The form can be submitted either by faxing to our secure eFax 1-877-331-1729 or by mail to Healthix, Attn: Compliance Department, 551 North Country Rd, 2nd Floor, St. James, NY 11780.

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 Healthix.

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. Please keep a copy of the form for your records after you sing and send it to Healthix. We will notify you of the receipt of the form and will also notify you of the effective date the Deny All request has been processed in our system after positive identification is confirmed.

_____ _____

Patient Name (Print) Date of Birth

_____ _____

Patient Signature Date of Signature

_____

Patient Address/ City/ State/ Zip Code, Phone Number

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)

Notary Acknowledgement

State of:_____) County of:_____) ss:

On this _____ day of _____ in the year _____, before me, the undersigned notary public, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that their executed the same in their capacity(ies), and that by their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

_____ Notary Public _____Registration Number _____Expiration Date