



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

New York State Department of Health

Patient Name	Date of Birth	Patient Identification Number Office Use Only
Patient Address		

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 Kips Bay Endoscopy Center LLC to obtain access to my medical records through the health information exchange organization called Healthix. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Healthix is a not-for-profit organization that shares information about people's health electronically to improve the quality of healthcare and meets the privacy and security standards of HIPAA, the requirements of the federal confidentiality laws, 42 CFR Part2, and New York State Law. To learn more visit Healthix's website at [www.healthix.org](http://www.healthix.org).

**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.**

<b>My Consent Choice.</b> 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.
<input type="checkbox"/> <b>1. I GIVE CONSENT</b> for Kips Bay Endoscopy Center LLC to access ALL of my electronic health information through Healthix to provide health care.
<input type="checkbox"/> <b>2. I DENY CONSENT</b> for Kips Bay Endoscopy Center LLC to access my electronic health information through Healthix for any purpose.

If I want to deny consent for all Provider Organizations and Health Plans participating in Healthix to access my electronic health information through Healthix, I may do so by visiting Healthix's website at [www.healthix.org](http://www.healthix.org) or calling Healthix at 877-695-4749.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)



**Details about the information accessed through Healthix 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 listed may access ALL of your electronic health information available through Healthix. 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
  - Medication and Dosages
  - Diagnostic Information
  - Allergies
  - Substance use history summaries
  - Clinical notes
  - Discharge summary
  - Employment Information
  - Living Situation
  - Social Supports
  - Claims Encounter Data
  - Lab Test
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 Healthix. You can obtain an updated list at any time by Healthix's website at [www.healthix.org](http://www.healthix.org) or by calling 877-695-4749.
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 patient's consent for certain public health and organ transplant purposes. These entities may access your information through Healthix 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 Kips Bay Endoscopy Center LLC at 212-889-5477; or visit Healthix's website: [www.healthix.org](http://www.healthix.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, death or until such time as Healthix ceases operation. If Healthix 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 Healthix 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.

# Insurance Verification & Referring Physician

Please Print Legibly and Sign Below

Date of Birth	Birth Sex	Gender	Marital Status	Preferred Method of Contact?		
				Mobile / Home / Email / Other _____		
First Name		Middle Initial	Last Name		SSN	
Home Phone Number		Mobile Phone Number		Email Address		
Home Address		Apt	City	State	County	Zip Code
Work Phone Number		Employers Name		Employers Address		

Other than the Doctor performing the procedure please indicate if there is another Doctor OR Referring Physician to send today's report to: [ Yes / No ] If yes, please provide their contact information below.

Dr. Name: \_\_\_\_\_

Dr. Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Telephone: \_\_\_\_\_

Fax (Required): \_\_\_\_\_

Fax (Required): \_\_\_\_\_

Did you bring a Health Care Proxy / Living Will / Advanced Directive to put on file? Yes / No

Name of Escort: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Primary Insurance Company		Primary Insurance Address or PO Box		
Policy Number / Member ID		Group Number		
Policy Subscribers Name		Date of Birth	Relationship	SSN or Last 4
Secondary Insurance Company		Secondary Insurance Address or PO Box		
Policy Number / Member ID		Group Number		
Policy Subscribers Name		Date of Birth	Relationship	SSN or Last 4

I understand that the information provided here may be used to process insurance claims.

I understand that any applicable physician, anesthesiologist and/or laboratory charges are independent of the KBEC charge and that any bills for these will be mailed separately.

Signature \_\_\_\_\_

Date \_\_\_\_\_

# Patient's Communication Preferences Regarding their PHI

## Telephone Communication Preferences

Home # \_\_\_\_\_

Work # \_\_\_\_\_

Mobile # \_\_\_\_\_

Place Patient Identification Label Here

Email \_\_\_\_\_

In order to best serve our patients and communicate regarding their services and financial obligations we will use all methods of communication provided to expedite those needs. By providing the information above I agree that Kips Bay Endoscopy Center, its legal agents, or affiliates may use the telephone numbers provided to send me a text notification, call using a pre-recorded/artificial voice message through the use of an automated dialing service or leave a voice message on an answering device.

If an email address has been provided, Kips Bay Endoscopy Center, its legal agents, or affiliates may contact me with an email notification regarding my care, our services, or my financial obligation.

I recognize that text messaging is not a completely secure means of communication because these messages can be accessed improperly while in storage or intercepted during transmission. The text messages you receive may contain your personal information. If you would like us to contact you by text message please sign this consent below. If you consent to receiving text messages you also agree to promptly update Kips Bay Endoscopy Center when your mobile phone number changes. You are not required to authorize the use of text messaging and a decision not to sign this portion of the authorization will not affect your health care in any way.

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Patient's Signature for consent to text message.

## Mail Communication Preferences

May we send mail to your home address? (If no, please provide an alternate mailing address below.)

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Other than you, your insurance company, and health care providers involved in your care, whom can we talk with about your health care information and/or financial information? (Check all that apply)

- |                          | <u>Name:</u>    | <u>Telephone</u> |                        |
|--------------------------|-----------------|------------------|------------------------|
| <input type="checkbox"/> | Spouse _____    | _____            | Consent to text? Y / N |
| <input type="checkbox"/> | Caretaker _____ | _____            | Consent to text? Y / N |
| <input type="checkbox"/> | Child _____     | _____            | Consent to text? Y / N |
| <input type="checkbox"/> | Parent _____    | _____            | Consent to text? Y / N |
| <input type="checkbox"/> | Other _____     | _____            | Consent to text? Y / N |

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information.

I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

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Patient or Personal Representative Signature

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Date

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Printed Name

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Relationship to Patient