HealthlinkNY Health Information Exchange
LEVEL ONE HEALTH INFORMATION EXCHANGE CONSENT FORM

ORGANIZATION: **Firstcare Medical, PC**

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 get health care. HealthlinkNY 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 the HealthlinkNY website at www.healthlinkny.com.

Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or deny consent may not be the basis for denial of health services. The choice you make in 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.

Please carefully read the Consent Form Information Sheet about how your information is used before making your decision.

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.

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 Name of Patient (Last Name)	(First Name)	Patient Date of Birth (MM / DD / YYYY)
Signature of Patient or Patient's Legal Representative	Relationship of Legal Representative to Patient (if applicable)	
Date of Signature (MM / DD / YYYY)	Print Name or Legal Representative (if applicable) Last Name, First Name	