One Time Authorization for Access to Minor Health Information
New York State Department of Health **Through a Health Information Exchange Organization**

Patient Name	Date of Birth	Patient Identification Number
Patient Address		
Provider Organization		
Date of Service		

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 "Provider Organization" listed above to obtain access to my medical records through the health information exchange organization called Interboro Regional Healthcare Information Organization d/b/a NY Care Information Gateway (NYCIG). If I give consent, my medical records from different places where I get health care can be accessed just this one time so that my treating doctor can better help in my care.

The choice I make in this form does NOT allow my healthcare provider to have ongoing access to my health information. This is a ONE TIME ONLY access.

My Consent Choice. ONE box is checked to the left of my choice.
☐ **1. I GIVE CONSENT** for "Provider Organization" to access one time only ALL of my electronic health information through NYCIG to provide health care.
☐ **2. I DENY CONSENT** for "Provider Organization" to access my electronic health information through NYCIG for any purpose.

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

Signature of Patient	Date
Print Name	

Details about the information accessed through NY Care Information Gateway (NYCIG) and the consent process:

1. **How Your Information May be Used**. Your electronic health information will be used **only** for the following healthcare services:

- **Minor Consented Services Treatment.** Provide you with medical treatment and related services.

2. What Types of Information about You Are Included. If you give consent, the Provider Organization listed may access ONE TIME ONLY ALL of your electronic health information available through NYCIG. 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

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 NY Care Information Gateway on their website: www.NYCIG.org.

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 NYCIG 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 the Provider Organization at: _____; or visit NYCIG's website: ***www.NYCIG.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 ONLY for the duration of treatment received on "Date of Service" listed.

10. Copy of Form. You are entitled to get a copy of this Consent Form**.**