ROCHESTER RHIO

Regional Health Information Organization

Patient Consent Form for Participating Provider Organization

(Name of Participating Provider Organization) _____

I have received the "Rochester RHIO Patient Brochure" which explains how the Rochester RHIO ("R-RHIO") works, how it operates, and how I can allow medical information about me to be accessed by the hospitals, nursing homes, home health agencies and other health care providers participating in the R-RHIO. If I sign this form as the Patient's Legal Representative, I understand that all references in this form to "me" or "my" refer to the Patient.

Each Participating Provider Organization ("Participating Provider") involved in my care must obtain my Consent separately to access my medical information through the R-RHIO. The provider organization named above is a Participating Provider in the R-RHIO. I understand that if I Give Consent below, I am authorizing the provider organization named above, including all individuals authorized by the provider organization named above, to use the R-RHIO to access my medical information through the R-RHIO.

1. **Purpose:** I understand that my medical information will be used by the provider organization named above only to provide me with medical treatment, to assess and improve the quality of medical care, and for disease management programs.
2. **Types of Information:** I understand that this Consent permits the provider organization named above to access ALL of my medical information, including but not limited to, sensitive information related to the following:
   - HIV/AIDS
   - Genetic Disease or Genetic Tests
   - Sexually Transmitted Diseases
   - Mental Health
   - Alcohol or Drug Abuse Treatment
   - Family Planning
3. **Health Information Sources:** Information accessed through the R-RHIO comes from a variety of sources ("Health Information Sources"). These Health Information Sources may include Participating Providers, other health care providers (including pharmacies and clinical laboratories), health insurers, the New York State Medicaid program and other health information exchanges. A complete list of current Health Information Sources may be found at www.grrhio.org. This list will change from time-to-time as the R-RHIO continues to grow.
4. This Consent permits the provider organization named above to access medical information created both before and after the date I sign this form. Anyone who receives HIV, alcohol or drug abuse treatment, or mental health treatment information about me from the R-RHIO, is prohibited from redisclosing this information unless I consent or the redisclosure is permitted under federal or state law. Other information disclosed under this consent may no longer be protected by federal or state law. The New York State Division of Human Rights can be called (585-238-8250) with questions or complaints regarding HIV/AIDS discrimination. I understand that if I give consent, my Consent will remain in effect until I withdraw consent or the R-RHIO stops operating, whichever comes first.
5. I understand that if I change my mind I can withdraw my consent at any time by signing a Withdrawal of Consent Form I can obtain from the R-RHIO. If I withdraw consent, the provider organization named above will no longer be able to routinely access medical information about me through the R-RHIO unless and until I again Give Consent by signing and completing a new Patient Consent Form. The withdrawal of consent will not affect the exchange of medical information made while my consent was in effect.
6. I understand that if I Deny Consent below, the provider organization named above will not access medical information through the R-RHIO — even in an emergency.
7. I understand that the decision to participate in the R-RHIO is voluntary. No Participating Provider will deny me medical care and my insurance eligibility will not be affected if I Deny Consent to participate in the R-RHIO.
8. I understand I will get a copy of this form after I sign it.

I hereby:

☐ **Give Consent**

☐ **Deny Consent**

for the provider organization named above to access ALL of my medical information from all Health Information Sources through the R-RHIO.

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