PATIENT NAME:

PATIENT DATE OF BIRTH: MR #:

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Adirondack Radiology Associates, P.C. (ARA) to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Adirondack Radiology Associates, P.C.'s Notice of Privacy Practices provides a more complete description of such uses and disclosures.

With this consent, ARA may contact me at my home or alternative location by telephone (including answering machine and voice mail), mail (marked Personal and Confidential), or email, in order to carry out various TPO activities, including but not limited to: appointment reminders, insurance data, and information pertaining to my clinical care, including laboratory results.

RECEIPT OF NOTICE OF PRIVACY PRACTICES: I have been offered a copy of the Notice of Privacy Practices from Adirondack Radiology Associates, P.C. concerning how the use of disclosure of protected health information will be handled by the practice.

HEALTHeCONNECTIONS ELECTRONIC DATA ACCESS CONSENT FORM

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 Adirondack Radiology Associates, PC to obtain access to my medical records through the health information exchange organization called HealtheConnections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network.
HealtheConnections 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 HealtheConnections website at
http://healtheconnections.org

Your Consent Choices. You can fill out this form now or in the future.

____**I GIVE CONSENT to Adirondack Radiology Associates, P.C. to access ALL** of my electronic health information through HealtheConnections ro provide health care services,(including emergency care).

____**I DENY CONSENT to Adirondack Radiology Associates, P.C. to access** my electronic health information through HealtheConnections for any purpose, *even in a medical emergency*.

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.

Signature of Patient, Parent or Legal Guardian: Date of Service: Witness:

____ _____/_____/_____ __________________