Asthma & Allergy Associates P.C.

Elliot Rubinstein, M.D. Mariah Pieretti, M.D. Rizwan Khan, M.D. Joseph Flanagan, M.D. Stella Castro, M.D. Julie McNairn, M.D.

Patient Information

Patient Name:_____ Date of Birth:____/____/____

Mailing Address:_____ Social Security No.:____-____-____

City:_____State:_____Zip:_____ Referred By:_____

Home Phone:____-____-____ Fax:____-____-____ Family Physician:_____

Cell:____-____-____ Work Phone:____-____-____, EXT:____ Occupation:_____

Employer:_____ Emergency Phone:_____

Emergency Contact:_____ Relationship to the Patient:_____

Pharmacy Used for Prescriptions:_____ Marital Status: S M D W

Sex: M F Smoker: Y N Full-Time Student: Y N Email:_____

Place of Residence: House Apartment Nursing Home School Other:_____

How did you hear about us? Patient Ins. Co. Newspaper Phone Book Web Search Other:_____

The person who is responsible is responsible for my bills and/or carries my insurance coverage

Name:_____ Relationship to the Patient:_____

Mailing Address:_____ Date of Birth:____/____/____

City:_____State:_____Zip:_____ Social Security No.:____-____-____

Home Phone:____-____-____ Fax:____-____-____ Employer:_____

Cell:____-____-____ Work Phone:____-____-____, EXT:____ Occupation:_____

Marital Status: S M D W Email:_____

Insurance Information

Insurance Company:_____ Policy Holder's Name:_____

Relationship to the Patient:_____ Policy No.:_____ Group No.:_____

Effective Date of Primary Insurance:___-___-___ Effective Date of Secondary Insurance:___-___-___

Secondary Insurance :_____ Policy Holder's Name:_____

Relationship to the Patient:_____ Policy No.:_____ Group No.:_____

Primary Care Physician (as stated on insurance card):_____

I certify that the information given by me in applying for payment under my insurance carrier(s) is correct. I authorize any holder medical/insurance information about me to release to my physician/insurance(s) any information required to process my claims. I understand that to knowingly withhold insurance reimbursement payments for medical services rendered would be committing a wrongful act. I, request that reimbursement from my insurance(s) be made to the physician's office that has rendered service to me. I attest that the information I have given on this form is true and correct to the best of my knowledge.

_____ Date:____/____/____

(Signature)

We are a fragrance-free office *Please bring your insurance card(s), picture ID, any co-pay*

No antihistamines for 72-hours before patient's appointment

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840 Hanshaw Road, Ithaca, NY 14850 ~ Phone 1-800-88-ASTHMA 607-257-6563 Fax 607-257-1420
3533 State Highway Route 281, Suite B, Cortland, NY 13045 ~ Phone 607-753-9604 Fax 607-753-8730
216 West Gray Street, Elmira, NY 14901 ~ Phone 607-733-5086 Fax 607-733-3855
4402 Medical Center Drive, Suite 402, Fayetteville, NY 13066 ~ Phone 315-663-0005 Fax 315-663-0097
1550 Vestal Parkway East, Suite 4, Vestal, NY 13850 ~ Phone 607-766-0235 Fax 607-766-0238

NOTICE OF PROTECTED HEALTH INFORMATION PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

As part of the healthcare service you receive from Asthma & Allergy Associates P.C., health records are generated and maintained describing your care, including but not limited to: your name, address, phone number, social security number, health history, symptoms, examination and test results, diagnoses, procedures, treatment, and plans for future care or treatment. This information is called "Protected Health Information."

This Notice of Privacy Practices describes how Asthma & Allergy Associates P.C. may use and disclose your information, and the rights that you have regarding your health information.

Uses and Disclosures of Health Information Without Authorization

When you obtain services from Asthma & Allergy Associates P.C., certain uses and disclosures of your health information are necessary and permitted by law in order to treat you, to process payments for your treatment, and to support the operations of the entity and other involved providers. The following categories describe ways that we use or disclose your information, and some representative examples are provided in each category. All of the ways your health information is used or disclosed should fall within one of these categories.

Your health information will be used for treatment. For example: Disclosure of medical information about you may be made to doctors, nurses, technicians, or others who are involved in treating you. This information may be disclosed to other physicians who are treating you or to other healthcare facilities involved in your care. Information may be shared with pharmacies, laboratories, or radiology centers for the coordination of different treatments.

Your health information will be used for payment. For example: Health information about you may be disclosed so that the services provided to you may be billed to an insurance company or a third party. Information may be provided to your health plan about treatment you are going to receive in order to obtain prior approval or to determine if your health plan will cover treatment.

Your health information will be used for healthcare operations. For example: The information in your health record may be used to evaluate and improve the quality of the care and services we provide.

Business associates. There are some services that we provide through contracts with third party business associates. Examples include: external laboratories, transcription agencies, copying services, and clinical research studies. To protect your health information, Asthma & Allergy Associates P.C. will require these business associates to properly protect your information.

Disclosures Required by Law or Otherwise Allowed Without Authorization or Notification

The following disclosures of health information may be made according to state and federal law without your written authorization or verbal agreement:

When disclosure is required by federal, state, or local law, judicial or administrative proceedings, or for law enforcement. Examples would be reporting gunshot wounds or child abuse, or responding to court orders;

For public health purposes, such as reporting information about births, deaths, and various diseases, or disclosures to the FDA regarding adverse events related to foods, medications, or devices;

For health oversight activities such as audits, inspections, or licensure investigations;

To organ procurement organizations for the purpose of tissue donation and transplant;

For research purposes, when the research has been approved by an institutional review board that has reviewed the research proposal and established guidelines to provide for the privacy of your health information;

To coroners and funeral directors for the purposes of identification, determination of the cause of death, or to perform their duties as authorized by law;

To avoid a serious threat to the health or safety of a person or the public;

For specific government functions, such as the protection of the President of the United States;

For Workers' Compensation purposes;

To military command authorities as required for members of the armed forces;

To authorized federal officials for national security and intelligence activities as authorized by law;

To correctional institutions or law enforcement officials concerning the health information of inmates, as authorized by law.

Other Allowable Uses and Disclosures Without Authorization: Other uses or disclosures of your health information that may be made include:

Contacting you to provide appointment reminders for treatment or medical care, as well as to recommend treatment alternatives;
Notifying you of health-related benefits and services that may be of interest to you;
Notifying you of clinical research studies that may be of interest to you.

Required Uses and Disclosures: Under the law, we must make disclosures when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with federal privacy law.

Minimum Necessary: We will make reasonable efforts to disclose, or request of another covered entity, only the minimum necessary PHI to accomplish the intended purpose. Personnel in our office will only have access to PHI that is reasonably necessary to performance of the individual's job.

Staff Training: We will train all members of our workforce in these Privacy Policies & Procedures, as necessary and appropriate for them to carry out their functions. Each staff member will be trained within a reasonable time after the member starts employment in this practice.

USES AND DISCLOSURES REQUIRING AUTHORIZATION

Any other uses or disclosures of your health information not addressed in this Notice or otherwise required by law will be made only with your written authorization. You may revoke such authorization at any time.

YOUR INDIVIDUAL RIGHTS UNDER HIPAA

1. You have the right to request restrictions on certain uses and disclosures of your Protected Health Information. For example, you may wish to restrict your employer from knowing about a medical condition. Regardless of your request please know that the HIPAA rules allow our office to share your Protected Health Information with the Covered Entities.
2. You have the right to receive your Protected Health Information in a confidential communication from our office, such as the U.S. Mail.
3. You have the right to inspect and request a copy of your Protected Health Information. Copies of your Protected Health Information are available for a reasonable fee paid to our office to cover our staff's time and reproduction of materials.
4. You have the right to request that we amend your Protected Health Information. In some cases, we may require these requests to be in writing and be supported by a reason for the change. Generally, this will not apply to such routine changes as address and phone number listings.
5. You have the right to receive, upon request, an accounting of your Protected Health Information that we have provided to Non-Covered Entities.
6. If you have read and responded to this notice through electronic media such as our practice website or e-mail, you have the right to receive a paper copy of this notice upon request. If you would like to exercise any of these rights, please contact the HIPAA Compliance Department in our office at (607) 257-6563/1-800-88-ASTHMA, and we will make the necessary arrangements for you.

Asthma & Allergy Associates P.C. is required by law to maintain the privacy of your Protected Health Information and to provide you with this notice of our legal duties and privacy practices as they apply to your Protected Health Information. We are also required to abide by the terms of this notice, which are currently in effect.

In the future, we reserve the right to change the terms contained in this notice and make any new provisions effective for all of the Protected Health Information that we maintain. In the event we elect to change the terms of this notice, a new notice will be posted in our office and on our practice website. In addition, you may receive notification by direct mail or other such communications our practice may implement from time to time.

Should you ever believe that your privacy rights have been violated, we request that you file a complaint with our office by contacting our HIPAA Compliance Department at (607) 257-6563/1-800-88-ASTHMA. Lastly you may register your complaint with the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights. As part of our commitment to you, we value your privacy and take every precaution in our practice to preserve your right to that privacy. Any complaint you file will be used strictly to improve our operation procedures, and in no way will you be retaliated against for filing a complaint.

My signature below certifies I have read and understand the above terms and conditions of this notice.

_____

Patient/Legal Representative Signature

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PATIENT PRIVACY METHOD OF CONTACT INFORMATION

Pat Whole Name (First Name First) **DOB:Pat DOB** **Age:**AgeDetailPlural **Acct. #:**Acct #

Mobile Text/Cell: RP Cell Phone **Home:** RP H Phone **Work:** RP W Phone

E-mail: Patient Email **Other:**

You may contact me or my legal guardian with in the following manner. I have indicated in numeric order my preference with a 1 as my preferred method of contact followed by a 2 and 3.

Appointment Information		**Medical Information**	
Home Phone (Include Auto Call)?	☐1 ☐2 ☐3	Home Phone (Include Auto Call)?	☐1 ☐ 2 ☐ 3
Mobile (cell) Phone (Include Auto Call)?	☐1 ☐2 ☐3	Mobile (cell) Phone (Include Auto Call)?	☐1 ☐ 2 ☐ 3
Mobile (cell) Text (Include Auto Text)?	☐1 ☐2 ☐3	Mobile (cell) Text (Include Auto Text)?	☐1 ☐ 2 ☐ 3
Work Phone?	☐1 ☐2 ☐3	Work Phone?	☐1 ☐ 2 ☐ 3
Send via Mail?	☐1 ☐2 ☐3	Send via Mail?	☐1 ☐ 2 ☐ 3
Send via E-mail?	☐1 ☐2 ☐3	Send via E-mail?	☐1 ☐ 2 ☐ 3
Appointment Information only	☐1 ☐2 ☐3	Appointment Information only	☐1 ☐ 2 ☐ 3

Listed below are individual(s) you may communicate with regarding my health care. This is other than or, in addition to, those parent(s) or legal guardian(s) who have signed this authorization below.

1) Name:
Relationship to Patient:
Emergency Phone Number:
Please Specify: ☐ Home ☐ Mobile

2) Name:
Relationship to Patient:
Emergency Phone Number:
Please Specify: ☐ Home ☐ Mobile

Patient/Legal Representative Signature

Relationship to the Patient:
☐ Mother ☐ Father ☐ Grandmother ☐ Grandfather
Printed Name if above is a Legal Representative ☐ Aunt ☐ Uncle ☐ Brother ☐ Sister ☐ Other:

Today's Date: Full Mth day, Year **Expiration Date of Consent:** Until Rescinded

Cayuga Area Plan, Inc.
Cayuga Area Preferred, Inc.

Clinical Integration Privacy Notice & Consent Form

We are pleased to be part of the Cayuga Area Preferred ("CAP") Clinical Integration Program. Clinical Integration is intended to improve the safety, efficiency, and quality of health care by allowing all health care providers participating in the CAP Clinical Integration Program to have access to and share data in your medical record in order to provide care to you and for purposes of improving the quality of care in the community. To learn more about Clinical Integration please talk to your physician. You can also call CAP at (607)252-3694.

Providers participating in the Clinical Integration Program are able to access protected health information (PHI) about you collected or accessible from all places where you get health care and from the insurance companies that pay for your health care. This information is only to be used in connection with providing care to you and for purposes of improving the quality of care in the community and is only open to providers participating in the CAP Clinical Integration Program and their staffs. You may decide whether or not to allow CAP participating providers and their staffs to access your protected health information. **Your choice to give or deny consent will not affect your ability to get medical care or health insurance coverage and will not be the basis for denial of health services.**

Furthermore, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you have certain rights to privacy regarding protected health information. A description of those rights together with the purposes for which your protected health information may be used or disclosed is set forth in this provider's Notice of Privacy Practices, a copy of which has been provided to you.

If you sign this form, you may request, in writing, restrictions on how your protected health information is used or disclosed to carry out treatment, payment or healthcare operations within the network of providers participating in the CAP Clinical Integration Program. **Please carefully read the information on the back of this form before making your decision.**

By signing this form, you give consent for purposes of providing care to you for all providers participating in the CAP Clinical integration Program and their staffs to access ALL of your protected health information available through a database maintained by CAP and from other sources made available to CAP participating providers, including the electronic medical system of Cayuga Medical Center (together, this information is hereinafter referred to as the "Cap Database"). You further acknowledge that you have received this provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of your protected health information.

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

Cayuga Area Plan, Inc.
Cayuga Area Preferred, Inc.

Details About the CAP Database.

1. How Will Information be Used?
Your electronic health information will be used by providers participating in the CAP Clinical Integration Program **only** to:

- Provide you with medical treatment and related services
- Evaluate and improve the quality of medical care provided to all patients.

2. What Types of Information Are Available?
The CAP Database includes records of participating healthcare providers, facilities, and claims submitted to and/or paid by your health insurance company. This information may be created before and after the date you sign this form and may also include information that relates to sensitive health conditions, such as:

- Alcohol or drug use problems/treatment
- Birth control, pregnancy and abortion (family planning)
- Genetic (inherited) diseases or tests
- HIV/AIDS and Sexually transmitted diseases
- Mental health conditions

3. Who May Access Information About You, If You Give Consent.
Only doctors and other health care providers and their staffs who are involved in your medical care and who participate in the CAP Clinical Integration Program may access your protected health information.

4. Penalties for Improper Access to or Use of Your Information. There are penalties for inappropriate access to or use of your protected health information. If, at any time, you suspect that someone who should not have seen or gotten access to information about you from the CAP Database has done so, call CAP at: (607)252-3694; or call the NYS Department of Health at 877-690-2211.

5. Re-disclosure of Information.
Persons who access information through the CAP Database must comply with all the federal and state privacy laws which restrict re-disclosure about your health information. Access to information in the CAP Database does not change these restrictions.

6. Effective Period. This consent will remain in effect until the day you withdraw your consent or the CAP Clinical Integration Program ceases all operations.

7. Withdrawing Your Consent. You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to any provider participating in the CAP Clinical Integration Program. You can get these forms from your healthcare provider or by calling CAP at (607)252-3694.

Details about the information accessed through HealtheConnections **and the consent process:**

1. **How Your Information May be Used**. Your electronic health information will be used **only** during this visit for **minor consented services** treatment.

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 HealtheConnections. 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	HIV/AIDS
Birth control and abortion (family planning)	Mental Health conditions
Genetic (inherited) diseases or tests	Sexually Transmitted diseases

   If you have received alcohol or drug abuse care, your record may include information related to your alcohol or drug abuse diagnoses, medications and dosages, lab tests, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social supports, and health insurance claims history.

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 HealtheConnections website at http://healtheconnections.org/ or by calling 315.671.2241 x5.

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 HealtheConnections 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: (607) 274-4615 or visit HealtheConnections' website: http://healtheconnections.org/ or by calling 315.671.2241 x5; 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. **Information about the services you have consented to receive may not be shared with your parents or guardians unless you want that information to be shared and you give your consent.**

8. **Effective Period**. This Consent Form will remain in effect ONLY for the duration of minor consented services treatment received on the date signed.

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

Cayuga Area Plan, Inc.
Cayuga Area Preferred, Inc.

HealtheConnections

New York State Department of Health

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

Patient Name	Date of Birth
Other Names Used (e.g., Maiden Name):	

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 **Cayuga Area Plan, Inc ("CAP") and the physicians, physician practices, and hospitals participating in CAP (see *http://www.CAPNY.com* for full list)** to obtain access to my medical records through the health information exchange organization called HealtheConnections, and any viewer or portal displaying data supplied by 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/ .

My information may be accessed in the event of an emergency, unless I complete this form and check box #3, which states that I deny consent *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.

My Consent Choice. 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.

☐ **1. I GIVE CONSENT** for **Cayuga Area Plan, Inc ("CAP") and the physicians, physician practices, and hospitals participating in the Cayuga Area Physicians Alliance, Inc.** to access ALL of my electronic health information through HealtheConnections to provide health care services (including emergency care).

☐ **2. I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY** for **Cayuga Area Plan, Inc ("CAP") and the physicians, physician practices, and hospitals participating in the Cayuga Area Physicians Alliance, Inc.** to access my electronic health information through HealtheConnections.

☐ **3. I DENY CONSENT** for **Cayuga Area Plan, Inc ("CAP") and the physicians, physician practices, and hospitals participating in the Cayuga Area Physicians Alliance, Inc.** to access my electronic health information through HealtheConnections for any purpose, ***even** in a medical emergency*.

If I want to deny consent for all Provider Organizations and Health Plans participating in HealtheConnections to access my electronic health information through HealtheConnections, I may do so by visiting HealtheConnections website at http://healtheconnections.org/ or calling HealtheConnections at 315.671.2241 x5.

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)

CAP: Cayuga Area Plan Inc.
Cayuga Area Preferred Inc.

HealtheConnections

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		

I choose to allow **Cayuga Area Plan, Inc ("CAP") and the physicians, physician practices, and hospitals participating in CAP (see** *http://www.CAPNY.com* **for full list)** where I am receiving care today for services that, as a minor, I am legally authorized to consent to, to obtain access to my medical records through the health information exchange organization called HealtheConnections. I understand that my medical records from different places where I get health care can be accessed just this one time so that my minor service provider can have the information needed to help give me the best care possible.

By signing below, I give consent for Cayuga Area Plan, Inc ("CAP") and the physicians, physician practices, and hospitals participating in CAP to access ONE TIME ONLY all of my electronic health information through HealtheConnections **in order to have access to my medical history and provide me with minor consented services health care.**

Signature of Patient	Date
Print Name	

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

Details about the information accessed through HealtheConnections **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 and/or Health Plan listed may access ALL of your electronic health information available through HealtheConnections. 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	HIV/AIDS
Birth control and abortion (family planning)	Mental Health conditions
Genetic (inherited) diseases or tests	Sexually Transmitted diseases

   If you have received alcohol or drug abuse care, your record may include information related to your alcohol or drug abuse diagnoses, medications and dosages, lab tests, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social supports, and health insurance claims history.

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 HealtheConnections. You can obtain an updated list at any time by checking HealtheConnections website at http://healtheconnections.org/ or by calling 315.671.2241 x5.

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 HealtheConnections 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: 607.274.4615 or visit HealtheConnections website at http://healtheconnections.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 or until such time as HealtheConnections ceases operation. If HealtheConnections 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 HealtheConnections 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.

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