Connecting Connecticut Through Health Information Technology

Patient Denial to Participate in the eHealthConnecticut Health Information Exchange (HIE)

I do not consent to the release of or access to ANY of my medical records by my health care providers, my health insurers, and other participating eHealthConnecticut organizations AND OR I have previously provided consent to participate in the eHealthConnecticut Health Information Exchange,allowing eHealthConnecticut to release and provide access to ALL of my medical records to my health care providers, my health insurers, and other participating eHealthConnecticut organizations and now want to withdraw that consent. 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.

By denying my consent, I understand that:

1. Health care providers and health insurers that I am enrolled with will not be able to access my medical information about me through the eHealthConnecticut HIE, even in an emergency.
2. My Denial of Consent will not affect the exchange of my medical information made while my Consent was in effect.
3. No eHealthConnecticut participating provider will deny me medical care and my insurance eligibility will not be affected based on my Denial of Consent.
4. If I wish to reinstate Consent, I may do so by signing and completing a new authorization form providing consent and returning it to an eHealthConnecticut HIE participating provider.
5. My Denial of Consent does not prevent my health care providers from submitting claims to my health insurer for reimbursement for services rendered to me.
6. I understand that I will get a copy of this form after I sign it.

_____ _____

Print Patient Name Patient Date of Birth

_____ _____

Patient Signature Date of Signature

_____

Patient Address/ City/ State/ Zip Code

_____ _____

Print Name of Patient's Legal Representative (if applicable) Authority to sign on behalf of patient (e.g., parent, guardian, other, please explain: _____)

If patient is a minor:

_____ _____

Signature of Parent Date of Signature

Name of eHealthConnecticut participating entity where this Authorization was signed: <insert name of participating entity>

March 11, 2010