UB|MD INTERNAL MEDICINE
PRIMARY & SPECIALTY CARE

1001 Main Street, Buffalo, New York 14203
1020 Youngs Road, Williamsville NY 14221
Phone: (716) 961-9900 Fax: (716) 961-9911

GASTROENTEROLOGY

REFERRING MD: _____ DATE: _____

PATIENT NAME: _____ DOB: _____

MEDICAL/SURGICAL HISTORY

List the medications (prescription or non-prescription) you are currently taking, the dosage, and how often you take them. Please print the name taking the spelling of the medication and the direction directly from the medicine bottles. It is also a good idea to make a list of your medications to carry with you at all times.

NAME OF MEDICATION	DOSAGE	HOW OFTEN

Pharmacy: _____ **Phone**: _____

Who is your primary medical doctor? _____

What is his/her office address and telephone number? _____

List the medications or other items you have had allergic reactions to and describe the reaction:

List any childhood and adult illnesses, hospitalizations and operations and their appropriate dates:

PATIENT NAME: _____ DOB: _____

SINCE YOUR 18TH BIRTHDAY, HAVE YOU:

	CHECK ONE	IF YES, BRIEFLY GIVE DETAILS
Had any fractures or dislocations to your bones or joints?	☐ YES ☐ NO	
Been injured in an automobile accident?	☐ YES ☐ NO	
Injured your head?	☐ YES ☐ NO	
Been injured in an assault or fight?	☐ YES ☐ NO	
Been injured after drinking?	☐ YES ☐ NO	

Do you smoke now? ☐ YES ☐ NO How many packs per day: _____

At what age did you start smoking? _____ When did you quit? _____

Do you drink alcoholic beverages? (beer, wine, mixed drinks, etc.): ☐ YES ☐ NO

If yes, what do you usually drink? _____ How often? _____

Have you ever had a drinking problem? ☐ YES ☐ NO When was your last drink? _____

FAMILY HISTORY

List all family members (living or deceased). Include parents, brothers, sisters, children and indicate their ages and any medical conditions:

FAMILY MEMBER	AGE	MEDICAL CONDITIONS

DO YOU HAVE A HEALTH CARE PROXY? ☐ YES ☐ NO

DO YOU HAVE ADVANCED DIRECTIVES? ☐ YES ☐ NO
If no, would you like information about it? ☐ YES ☐ NO

SOCIAL HISTORY

Indicate your employment: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled Other: _____

What is your occupation? _____

Do you live alone? ☐ YES ☐ NO If no, who is home with you? _____

If yes, who is available in times of need? _____ Telephone #: _____

PATIENT NAME: _____ DOB: _____

SYSTEM REVIEW

Check (✓ or **X**) any of the following systems if you have experienced the RECENTLY or REGULARY. Mark any symptoms you are unsure about with a question (**?**) mark:

_____ Change in weight (gain or loss)
_____ Fevers, chills, drenching sweats
_____ Excessive hunger or thirst
_____ Sensitivity to hot or cold
_____ Difficulty in thinking clearly
_____ Difficulty sleeping
_____ Unusual irritability
_____ Persistent troubling thoughts
_____ Hearing voices or seeing things
_____ Frequent crying spells
_____ Depression
_____ Change in skin or eye color
_____ Skin rash or spots
_____ Lumps under the skin
_____ Injury to head or eyes
_____ Frequent headaches
_____ Difficulty in seeing clearly
_____ Eye pain
_____ Difficulty hearing
_____ Unusual nasal drainage
_____ Frequent nose bleeds
_____ Sores in or around the mouth
_____ Sore teeth or gums
_____ Bleeding teeth or gums
_____ Frequent sore throats
_____ Hoarseness
_____ Difficulty breathing
_____ Frequent cough
_____ Pain or pressure in the chest
_____ Shortness of breath while lying down
_____ Rapid or fluttering heartbeat

_____ Swelling in the ankles
_____ Leg pain while walking
_____ Difficult/painful swallowing
_____ Frequent nausea/vomiting
_____ Vomited up blood
_____ Abdominal pain
_____ Constipation
_____ Diarrhea
_____ Painful bowel movements
_____ Blood in stool
_____ Loss of bowel/bladder control
_____ Difficulty urinating
_____ Unusual frequent urination
_____ Blood in the urine
_____ Penile sores/discharge
_____ Difficulty achieving erection
_____ Breast discharge
_____ Breast tenderness or lumps
_____ Change in breast size/shape
_____ Unusual vaginal bleeding
_____ Irregular menstrual periods
_____ Vaginal sores/discharge
_____ Stiff/painful/swollen joints
_____ Weakness in arm or leg
_____ Difficulty walking
_____ Loss of balance
_____ Loss of consciousness
_____ Blurring or loss of vision
_____ Uncontrolled movements
_____ Numbness or loss of sensation

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HIPAA Contact and Authorization for Release

1001 Main Street
Buffalo, NY 14203
P: (716) 961-9900
F: (716) 961-9911

1020 Youngs Rd.
Williamsville, NY 14221
P: (716) 961-9900
F: (716) 961-9911

6105 Transit Rd.
E. Amherst, NY 14051
P: (716) 348-3435
F: (716) 204-8229

300 Linwood Ave.
Buffalo, NY 14209
P: (716) 961-9400
F: (716) 961-9402

6400 Edgewood Dr.
Niagara Falls, NY 14304
P: (716) 898-4803
F: (716) 898-3928

462 Grider St.
Buffalo, NY 14215
Nephrology
P: (716) 898-4803
F: (716) 898-3928
Behavioral Med:
P: (716) 898-5671

Patient Name:	**Date of Birth:** / /

Receipt of Notice of Privacy Practices

I have received a copy of the UBMD Internal Medicine, Inc. Notice of Privacy Practice. (also available at UBMDIM.COM)

Signature:	Date: / /

☐ Patient refused and/or unable to sign
Staff member signature:

Authorization to Release Information to Family and/or Friends

Name	Relationship	Primary Phone	Secondary Phone

Authorization to Leave Messages

From time to time it may be necessary to leave you a message concerning appointments, financial issues, or other protected health information (PHI). Please indicate how you prefer we leave a message for you:

	Phone Number	May we leave a voice message?	May we leave a message with another person answering this phone?
Voice Mail on Preferred Phone Number	- -	☐ Yes ☐ No	☐ Yes ☐ No
Voice Mail on Alternate Phone Number	- -	☐ Yes ☐ No	☐ Yes ☐ No
		May we send a message?	
Send through US Mail		☐ Yes ☐ No	

Restrictions to Release of Information

Please list any restrictions regarding information to be released:

Signature

Signature:	Date: / /

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

PLEASE SEND TO PREVIOUS PRACTICE

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

Please complete

Name and address of doctor (or other health professional) to release this information (e.g., your previous primary doctor)

8. Name and address of person(s) or category of person to whom this information will be sent: **UBMD INTERNAL MEDICINE**

Please complete

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Only if to Atty/Gov

Authorization to Discuss Health Information

(b) ❑ By initialing here _____ I authorize _____
Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

Please complete

10. Reason for release of information: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:

Only if not patient

12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Please Sign/Date

_____ Date: _____
Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

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Buffalo, NY 14215
Nephrology
P: 716.898.4803
F: 716.898.3928
Behavioral Med:
P: 716.898.5671

UBMD Internal Medicine Patient Agreement

Thank you for choosing UBMD Internal Medicine as your healthcare provider. Our practice is committed to providing you with the highest quality care, service and access. In order to help accomplish these goals, below is some introductory information and our financial policy.

General Information
Billing Office: 716.816.7200
Hours: Monday - Friday 7:30 am – 4:30 pm
Patient Website: ubmdim.com

If you wish to contact a physician regarding a medical matter, please call the appropriate office above or use the Patient Portal (see information on page 2). **DO NOT contact physicians via University or buffalo.edu email**, as they are not HIPAA-compliant and do not offer protection for health information. A medical provider is on call seven (7) days a week to take urgent calls outside normal business hours. Your call will be returned within one (1) hour. **For emergencies, call 911.**

Our phone message is updated as needed to report any weather-related closings.

Appointments
Please arrive 15 minutes prior to your appointment time to register. For your benefit and the benefit of all our patients, we try to stay on schedule (though emergencies sometimes occur) and aim for patients to be in the exam room at their appointment time. You will receive an automated pre-appointment reminder call two (2) to five (5) business days before your appointment. It is important for you to notify our office if your phone number has changed. Please specify if you prefer your home or mobile number as your primary contact.

Prescription Refills.
For routine refills, please contact your pharmacy and have them send a prescription refill request electronically. Refills can be requested through our Patient Portal for those who are currently enrolled. Please allow five (5) business days to have all medications refilled. For refill requests needed in less than five (5) business days, contact the office.

Form Completion Fee
There will be a $10 service charge for completion of forms not associated with an office visit. This fee is required to be paid at the time of request. Please allow seven (7) business days for us to complete any forms.

Test Results
Please allow seven (7) business days for laboratory results or other diagnostic test results unless instructed by your physician. Your physician will review all test results and contact you if follow up is needed. Routine lab results may be relayed by postal mail, patient portal or telephone.

Address and/or Phone Number Change
Please advise our practice anytime there is a change in your address, phone number, or other contact information. Our staff is required to verify all demographic and insurance information at every visit.

Financial Policy
Your clear understanding of our Patient Financial Policy (available on our Patient Resources web page, or by request at the office) is important to us. Please ask if you have any questions about our fees, policies, or your responsibilities.

Insurance Verification and Copayments
Patients are expected to present valid photo identification and their insurance card at each visit. All co-payments and past due balances are due at the time of check-in unless previous arrangements have been made with a billing supervisor. Failure to pay your copay at the time of service will result in an additional $10 fee. We accept cash, check, credit card or flexible spending card. No post-dated checks are accepted. A $35 returned check fee is added to any insufficient funds amount owed by the patient. The patient may be placed on a cash-only basis following any returned check.

Insurance Claims
The practice will bill the patient's primary insurance company. In order to properly bill the insurance company, the practice requires that the patient disclose all insurance information including primary and secondary insurance, as well as any insurance changes. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although the practice may estimate the amount the insurance company may pay, it is the insurance company that makes the final determination of the patient's eligibility and/or benefits. The patient is responsible and agrees to pay for any non-covered services provided. If the insurance company is not contracted with the practice, the patient agrees to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance.

Participating Insurances
The practice accepts most insurance plans including but not limited to: Blue Cross/Blue Shield, Empire, Fidelis, Independent Health, Univera, United Healthcare, Wellcare, and Medicare. Participation in insurance plans may change. It is your responsibility to verify if UBMD Internal Medicine participates in your plan. If your physician does not participate with your insurance, you have the right to request an estimate of cost.

High Deductible Plans (Health Savings Accounts or Health Reimbursement Accounts)
If your insurance is a High Deductible Plan, you will be required to pay a $75 deposit prior to your visit. If the total cost of services rendered is more than $75 you will be billed for the remaining amount. If the cost of your visit is less than $75 we will send you a refund for the difference. Refunds will be issued within 60 days if the overall patient account has a credit balance.

Referrals and Authorizations
It is the patient's or guarantor's responsibility to be aware of the details of his/her insurance coverage, including any requirements for referrals and/or authorizations. Not all of our providers participate with all insurance companies. Please verify whether your physician accepts your insurance coverage. If your insurance company requires a referral and/or authorization (for specialist visits/testing), you are responsible for obtaining it. Failure to obtain the referral or preauthorization may result in a lower payment or no payment from the insurance company and the balance will be the patient's responsibility. To verify if we have received the appropriate referral or authorization, please contact our office.

Patient Portal
The UBMD FollowMyHealth Patient Portal provides all participating UBMD patients the ability to communicate securely and manage their own healthcare with UBMD providers, 24 hours, seven (7) days a week. All messages received through the Patient Portal will be answered within one (1) business day. The ability to view portions of your medical records, verify or request appointments, request prescriptions, update demographic information, receive reminders and ask a question of your provider are some functions of the portal. All patients are encouraged to notify our UBMD Internal Medicine staff by phone/at your next visit to request an invitation to create an account on FollowMyHealth to become participants of the UBMD Patient Portal.

Self-pay Accounts
Self-pay accounts are for patients without insurance coverage or patients without an insurance card on file with UBMD. This includes patients who have applied for Medicaid but who do not yet have a valid Medicaid number. The practice does not accept attorney letters or contingency payments. It is always the patient's responsibility to know if the practice participates with their insurance plan. If there is a discrepancy with the insurance information on file with the practice, the patient is considered self-pay unless otherwise proven. Self-pay patients are expected to make a down payment at the time of service *($115 for new patients* and *$75 for established patients*). If the down payment does not cover all treatment charges, the patient is billed for the remaining balance. Payment plans are available if needed. Please contact the billing office (716.816.7200) to discuss a mutually agreeable payment plan. It is not the intention of the practice to cause hardship to patients, only to provide them with the best care possible and the least amount of stress. Failure to make the deposit at the time of service, will result in an additional $10 fee.

Workers' Compensation and Automobile Accidents (No Fault)
In the case of a workers' compensation injury or automobile accident, the patient must have the claim number, phone number, contact person, and name and address of the insurance carrier with them at the office visit. If this information is not provided, the patient will be asked to either reschedule the appointment or pay for the visit at the time of service.

No Show/Cancellation Fee
The practice requires 24-hour notice of appointment cancellation. If this procedure is not followed, a $35 fee is assessed to the patient.

Medical Record Copies
Patients requesting copies of medical records are charged $.75 per page. A charge of $15 applies for the retrieval of records in off-site storage, including those medical records transferred from another practice.

Minors
The parent or guardian who holds the insurance for the child is considered the guarantor for the child and is responsible for full payment regardless of personal circumstances. A signed release to treat may be required for unaccompanied minors.

Outstanding Balance Policy
A billing statement is sent to the patient/guarantor upon rendering of services. Statements are mailed every twenty-eight (28) days thereafter. If a patient's account is sixty (60) days past due, the patient is sent a Final Collection letter requesting payment within fifteen (15) days. Telephone calls may be made to the patient prior to sending an account to a collection agency in a final attempt to collect the outstanding balance. If no payment is received, the account is sent to a collection agency. Statements returned with an invalid address, will be sent to the collection agency. Any account sent to a collection agency will include collection, attorney and court fees and may be reported to credit bureaus.

Patients with an outstanding balance of 120 days may be discharged from our practice unless a payment arrangement is made. If your account is unpaid, and no payment arrangement has been made, pursuant to this agreement, your account may be turned over to a collection agency.

Regardless of any personal arrangements that a patient might have with outside individuals or groups, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other individual.

Policy and Fee Changes
These policies and fees are subject to change. We will do our best to keep you informed of any modifications.

UBMD Internal Medicine

Assignment of Benefits, Financial Responsibility, Release of Information And Receipt of Notice of Privacy Practices

- **Assignment of Benefits**
  I hereby assign all medical and surgical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment directly to UBMD Internal Medicine for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.
  Please initial x_____

- **Financial Responsibility**
  I have requested medical services from UBMD Internal Medicine on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred during the course of treatment. I also acknowledge that I have read the financial policy of the practice, agree to be bound by its terms and understand that such terms may be amended from time-to-time by the practice.
  Please initial x_____

- **Release of Information**
  I authorize the release of necessary medical information to UBMD Internal Medicine for the purpose of processing this or any related claim. I also authorize UBMD Internal Medicine to release requested documentation of this claim or any related claim to myself and/or other health care providers involved in the treatment of my condition.
  Please initial x_____

- **Teaching Facility**
  I acknowledge that UBMD Internal Medicine is affiliated with the University at Buffalo School of Medicine and Biomedical Sciences and as such students may become involved in my care. If you are concerned about the involvement of medical students, please speak to the physician responsible for your care.
  Please initial x_____

- **Phone Notifications**
  I authorize UBMD Internal Medicine to remind me of my appointments and other useful information using automatic, prerecorded or artificial voice calls to me on the phone number I listed; even if it is a cellular phone number
  Please initial x_____

- **Notice of Privacy Practices**
  We are required to provide you a copy of our Notice of Privacy Practices which describes how medical information about you may be used and disclosed and how you can get access to this information. Any restrictions concerning the use of your personal medical information must be made in writing. By signing below, I acknowledge that I received a copy of UBMD Internal Medicine's Notice of Privacy Practices.
  Please initial x_____

Documentation of Good Faith Efforts – For UBMD Internal Medicine use only

A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of UBMD Internal Medicine's Notice of Privacy Practices. However, such acknowledgment was not obtained because:

_____ Patient refused to sign
_____ Due to an emergency, it was not possible to obtain an acknowledgement
_____ Unable to communicate with patient
_____ Other (please provide specific details)

_____
_____

_____ _____
Employee Signature Date

_____ _____
Patient Name (print) Patient Date of Birth

_____ _____
Patient Signature or Responsible Party if a Minor Date

HEALTHeLINK

Patient Consent to Participate in HEALTHeLINK Health Information Exchange
Level 1 Multi-Provider/Multi-Payer Consent

Please carefully read the information that follows before making your decision.

You may use this Consent Form to decide whether or not to allow Participating HEALTHeLINK Providers and Payers ("Participants") who are involved in your care to see and obtain access to your electronic health records for treatment and/or care management purposes. This form may be filled out now or at a later date. You can give consent or deny consent to some or all of the Participants. A complete list of Participants can be found at www.wnyhealthelink.com/Home/Patients/Participants. If you have any questions on completing this form go to www.wnyhealthelink.com/Home/Patients/PatientConsent. If you do not have internet access and would like a list of Participants or need help completing this form, please call (716)206-0993 ext 311. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services.**

In this Consent Form, you can choose whether to allow the Participants to obtain access to your medical records through a computer network operated by HEALTHeLINK, which is a part of a statewide healthcare computer network. This helps collect the medical records you have in different places where you get health care, and make them available electronically to the Participants rendering services to you.

SELECT ONLY ONE

☐ **YES** — **I GIVE CONSENT for all Participants who are involved in my care to access ALL of** my electronic health information through HEALTHeLINK. By checking this box you agree that, "Yes, the staff involved in my care including emergency care, quality improvement, care management, and pre-authorization activities at all the Participants may see and get access to all of my medical records through HEALTHeLINK."

☐ **YES EXCEPT** — **I GIVE CONSENT for all Participants who are involved in my care to access ALL** of my electronic health information through HEALTHeLINK except the following Participants:

Participant's Name **Participant's address or phone number**

These Participants cannot access my electronic health information via HEALTHeLINK *EXCEPT in a medical emergency*. If you have chosen to exclude any Participants, you **must** contact HEALTHeLINK at (716)206-0993 ext 311 to verify your form. If you wish to deny consent to additional Participants, please identify them on the Participant Exclusion Form and attach it to this form. You can find the form at www.wnyhealthelink.com/Home/Patients/PatientConsent. If you have attached the Participant Exclusion Form please check here ☐

☐ **NO EXCEPT** — **I DENY CONSENT for all Participants who are involved in my care to access** my electronic health information through HEALTHeLINK for any purpose, EXCEPT *in a medical emergency*. By checking this box you agree, "No, none of the Participants may be given access to my medical records through HEALTHeLINK unless it is a medical emergency."

☐ **NO NEVER** — **I DENY CONSENT for all Participants who are involved in my care to access** my electronic health information through HEALTHeLINK for any purpose, INCLUDING *in a medical emergency*.

NOTE: Unless you select "NO NEVER" New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through HEALTHeLINK.

PATIENT/LEGAL REPRESENTATIVE

Patient Last Name:

Patient First Name:

/ / ☐ **Male** ☐ **Female**

Patient Date of Birth:

Patient Address

City **State** **ZIP**

Signature of Patient or Patient's Legal Representative **Date of Signature**

Print Name of Patient's Legal Representative (if applicable)

Relationship of Legal Representative to Patient (if applicable)

☐ parent ☐ healthcare agent/proxy ☐ guardian ☐ other _____

Entity Consent Received By

WITNESS *

* If you are NOT completing this form in a Participant's office, you must have a witness complete the information below.

Print Name of Witness

Signature of Witness

Relationship of Witness to Patient (ex., spouse, son, neighbor, etc.)

HEALTHeLINK is a not-for-profit organization. It shares information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology (health IT). To learn more about ehealth in New York State, read the brochure, "Better Information Means Better Care." You can ask a Participant for it, or go to the website www.ehealth4ny.org

Details about patient information in HEALTHeLINK and the consent process:

1. **How Your Information Will be Used.**
   Your electronic health information will be used by the Participating Providers you approve **only** to:
   - Provide you with medical treatment and related services
   - Check whether you have health insurance and what it covers.
   - Evaluate and improve the quality of medical care provided to all patients.

   Your electronic health information will be used by the Participating **Payers** you approve **only** for:
   - **Quality Improvement Activities.** These include evaluating and improving the quality of medical care provided to you and all of the health insurer's members.
   - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of health care 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.
   - **Pre-Authorization Activities.** These include reviewing and evaluating medical information in order to pre-approve services requested by you or your health care provider.

   NOTE: The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

2. **What Types of Information about You Are Included**. If you give consent, the Participants you approve may access ALL of your electronic health information available through HEALTHeLINK. This includes information created before and after the date of this Consent Form. 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 relate to sensitive health conditions, including but not limited to:
   - Alcohol or drug use problems
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Mental health conditions
   - Birth control and abortion (family planning)
   - 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 ("Information Sources"). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other ehealth organizations that exchange health information electronically. A complete list of current Information Sources is available from HEALTHeLINK. You can obtain an updated list at any time by checking the HEALTHeLINK website at www.wnyhealthelink.com or by calling 716-206-0993 ext. 311.

4. **Who May Access Information About You, If You Give Consent.** Only these people may access information about you: doctors and other health care providers who serve on the medical staff of an approved Participating Provider who are involved in your medical care; health care providers who are covering or on call for an approved Participating Provider's doctors; and staff members of an approved Participants who carry out activities permitted by this Consent Form as described above in item one. A complete list of Participants is available from HEALTHeLINK at www.wnyhealthelink.com or by calling 716-206-0993 ext. 311.

5. **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 one of the Participants you have approved to access our records; or visit HEALTHeLINK's website at www.wnyhealthelink.com; or call HEALTHeLINK at 716-206-0993 ext. 311; or call the NYS Department of Health at 877-690-2211.

6. **Re-disclosure of Information.** Any electronic health information about you may be re-disclosed by the Participants to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information. HEALTHeLINK and persons who access this information through the HEALTHeLINK must comply with these requirements.

7. **Effective Period**. This Consent Form will remain in effect until the day you withdraw your consent. or HEALTHeLINK ceases to conduct business.

8. **Withdrawing Your Consent**. You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to one of the Participants. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms on HEALTHeLINK's website at www.wnyhealthelink.com or by calling 716-206-0993 ext. 311.

   Note: Organizations that access your health information through HEALTHeLINK while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

9. **Copy of Form**. You are entitled to get a copy of this Consent Form after you sign it.