[Participant Name]

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 the organization named above, 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 the organization named above 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** 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 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**.**