Finger Lakes IPA (DBA Forward Leading IPA) Patient Information Sharing Consent Form

Patient Name	Patient Date of Birth	Patient ID Number

By signing this form, you agree to have your health information shared by and among Finger Lakes IPA (DBA Forward Leading IPA) (the "IPA") and its participating provider organizations. The goals of the IPA and its participating provider organizations are in part to improve the integration of physical and behavioral health and to help healthcare providers improve quality of care. To support coordination of your care, health care providers and other people involved in your care need to be able to talk to each other about your care and share your health information with each other to give you better care. You will still be able to get health care and health insurance even if you do not sign this form.

The IPA may obtain your health information, including your health records, from participating provider organizations listed on the IPA website: www.fingerlakesipa.org. Participating provider organizations use and disclose health information through a computer system called Garage Solutions, LLC ("Garage").

If you give consent and sign this form, the IPA and any of its participating provider organizations are allowed to get, see, read and copy, and share by and among each other, ALL of your health information (including all of your health information obtained from the Garage) that they need to give you care, manage your care or review your care to make health care better for patients. The health information they may get, see, read, copy and share may be from before and after the date you sign this form. Your health records may have information about illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays, blood tests, or screenings), assessment results, and lists of medicines you have taken. Your health records may also have information on:

1. All of your substance use disorder information from all of your substance use disorder treatment programs;
2. Family planning services like birth control and abortion;
3. Genetic (inherited) diseases or tests;
4. HIV/AIDS;
5. Mental health conditions;
6. Sexually-transmitted diseases (diseases you can get from having sex);
7. Social needs information (housing, food, clothing, etc..) and/or
8. Assessment results, care plans, or other information you or your treatment provider enters into the Garage.

Your health information is private and cannot be given to other people without your permission under New York State and U.S. laws and rules. The IPA and its participating provider organization that can get and see your health information must obey all these laws. They cannot give your information to other people unless you agree or the law says they can give the information to other people. This is true if your health information is on a computer system or on paper. Some laws cover care for HIV/AIDS, mental health records, and substance use disorder records. The IPA participating provider organizations that use your health information and the IPA must obey these laws and rules.

Your Consent Choice

☐ **I GIVE CONSENT for the IPA and any of its participating provider organizations as listed on the IPA website to get ALL my health information through the Garage to give me care or manage my care, to check if I am in a health plan and what it covers, and to review and make the care of all patients better. I also AGREE that the IPA and any of its participating provider organizations as listed on the IPA website may share my health information by and among each other. I can change my mind and take back my consent at any time by signing a submitting a new Consent Form with my new choice and giving it to one of the IPA participating provider organizations.**

☐ **I DENY CONSENT for the IPA to access my health information through the Garage and deny consent for the IPA and its participating provider organizations to share my health information with each other unless they are otherwise authorized to share my information pursuant to 45 CFR Parts 160 and 164 (which are the rules referred to as "HIPAA"), 42 CFR Part 2 and New York State laws.**

Finger Lakes IPA (DBA Forward Leading IPA) Patient Information Sharing Consent Form

Details About Patient Information and the Consent Process

1. **How will the IPA and its participating provider organizations use my health information?** If you consent, the IPA and its participating provider organizations will use your health information for:

- **Treatment Services**. Provide you with medical and behavioral health treatment and related services.
- **Insurance Eligibility Verification**. Check whether you have health insurance and what it covers.
- **Care Coordination and Case Management Activities**. These activities include assisting you in obtaining appropriate 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 care.
- **Quality Improvement Activities**. Evaluate and improve the quality of care provided to you and all patients.

The choice you make does NOT let health insurers see your information to decide whether to give you health insurance or pay your bills.

2. **Where does my health information come from?**
Your health information comes from places and people that gave you health care or health insurance in the past. These may include hospitals, doctors, drugstores, laboratories, health plans (insurance companies), the Medicaid or Medicare programs, and other groups that share health information. You can get a list of all the places and people by calling your treatment provider [INSERT PROVIDER NAME] at [INSERT PROVIDER Phone #]. Your treatment provider may also print out information about these computer systems for you.

3. **What laws and rules cover how my health information can be shared?**
Laws and regulations include New York Mental Hygiene Law Section 33.13, New York Public Health Law Article 27-F, and federal confidentiality rules, including 42 CFR Part 2 and HIPAA.

4. **If I consent, who can get and see my information?**
The only people who can see your health information are those who you agree can get and see it, like doctors and other people who work for the IPA including those who review your information to make health care better for all patients and the IPA's participating provider organizations including those who are involved in your health care and people who work for an IPA participating provider organization who is giving you care to help them check your health insurance. The current list of the IPA participating provider organizations can be obtained from the IPA website at: www.fingerlakesipa.org.

5. **What if a person uses my information and I didn't agree to let them use it or I experience discrimination?**
If you think a person used your information, and you did not agree to give the person your information, call one of the IPA participating provider organizations you have said can see your records, the IPA at privacy@fingerlakesipa.org, the United States Attorney's Office at (585) 263-6760, or the NYS Office of Mental Health Customer Relations at 800-597-8481. If you experience discrimination because of the release or disclosure of HIV/AIDS-related information, you may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting your rights.

6. **How long does my consent last?**
Your consent will last until the day you change your consent choice or death.

7. **What if I change my mind later and want to take back my consent?**
You can change your consent choice at any time by submitting a new Patient Information Sharing Consent Form with your new choice and giving it to an IPA participating provider organization. Note: Even if you later decide to take back your consent, the IPA and/or its participating provider organizations who already have your information do not have to take it out of their records.

8. **How do I get a copy of this form?**
You can have a copy of this form after you sign it.

Acknowledgement of Understanding and Signature

I acknowledge and understand the terms of this consent form. If I have questions about this form, I may contact my health care provider or the IPA. I have received a copy of this form.

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