Visiting Nurse Service Of New York®
We Bring The Caring Home®

CONSENT FOR HEALTH INFORMATION EXCHANGE PARTICIPATION

PATIENT NAME: (PLEASE PRINT)	CURRENT VNSNY PROGRAM: ☐ ACUTE CARE ☐ CONGREGATE CARE ☐ LONG-TERM CARE ☐ CHILDREN & FAMILY SERVICES ☐ VNS CHOICE ☐ VNS HOSPICE	TEAM:	MRN:

I acknowledge the receipt of the VNSNY Health Information Exchange Fact Sheet, which describes the purpose of Health Information Exchanges, how they operate, and how VNSNY will share my health information if I give my consent.

I understand that by signing this consent, I give my permission for VNSNY to share my health information with other health care providers, and to access it from other health care providers, as described in the Health Information Exchange Fact Sheet, including any of the following types of sensitive information as defined in State and Federal laws:

- Information from facilities licensed by the NYS Office of Mental Health.
- Information from a federally assisted alcohol and drug abuse program indicating alcohol or substance abuse.
- Information indicating certain healthcare services to minors, including family planning and abortion services, testing for HIV and sexually transmitted diseases, and mental health and substance abuse treatment.
- The results of genetic tests.
- Information indicating HIV or AIDS such as diagnoses, lab results, medications, or notes or documents indicating HIV or AIDS.

I understand that I can revoke (take back) this consent at any time except that the revocation will not affect health information shared or exchanged while my consent was in effect. This consent will not expire and will remain in effect unless revoked in writing. I understand that if I wish to revoke this consent, I may do so by either calling the VNSNY Privacy Official to request a Revocation Form to complete and return or by writing my request to revoke this consent to the VNSNY Privacy Official at the following address:

Privacy Official
Visiting Nurse Service of New York
107 East 70th Street
New York, NY 10021
212-609-6345

I understand that my consent is voluntary. VNSNY will not deny me services based on my refusal to sign this consent.

I understand that this consent is valid for all VNSNY Programs.

I hereby ☐ Grant ☐ Do **Not** Grant

the Visiting Nurse Service of New York my consent to share my health information with other healthcare providers, and to access my information from other healthcare providers, through the electronic Health Information Exchanges, as described in the VNSNY HEALTH INFORMATION EXCHANGE FACT SHEET.

If not the patient, name (print) of person signing this form:	Authority to sign this form on behalf of the patient (example: parent, guardian, health care proxy):

Signature of patient or representative authorized by law ____________________ Date ____________