



Regional Health Information Organization

Level 2 Research Authorization for Access to Patient Information Through a Health Information Exchange Organization

New York State Department of Health

Provider Organization: _____

Patient Name	Date of Birth
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In this Consent Form, you can choose whether to allow researchers working with [Name of Provider Organization] to obtain access to your medical records for research purposes through a computer network operated by Rochester RHIO, which is part of a statewide computer network. This can help collect the medical records you have in different places where you get health care, and make them available electronically to these researchers. This Consent Form should read together with the [Name of Informed Consent For Research Document] you signed when you agreed to participate in one or more research studies.

You may use this Consent Form to decide whether or not to allow researchers working with [Name of Provider Organization] to see and obtain access to your electronic health records in this way. **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, [except that, if you choose to deny consent you will not be eligible to participate in _____].**

If you check the "I GIVE CONSENT" box below, you are saying "Yes, [Name of Provider Organization's] researchers may see and get access to all of my medical records through Rochester RHIO for the research activities described in Section 1 of this Consent Form."

Rochester RHIO 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 [Name of Provider Organization] for it, or go to the website www.ehealth4ny.org.

Please carefully read the information on the back of this form before making your decision.

I GIVE CONSENT for [Name of Provider Organization's] researchers to access my electronic health information through Rochester RHIO for the research activities described in Section 1 of this Consent Form.

Signature of Patient or Patient's Legal Representative	Date of Signature
Print Name of Legal Representative (if applicable)	Authority to Sign on Behalf of Patient (e.g, healthcare agent, guardian or parent)

Details about patient information in Rochester RHIO and the consent process:

- 1. How Your Information Will Be Used.** Your electronic health information will be used by [Name of Provider Organization's] researchers to conduct the following research studies: [Insert Name and Description of Research Studies]. Additional information about these studies is provided in the [reference informed consent document]
- 2. What Types of Information about You Are Included.** If you give consent, [Name of Provider Organization's] researchers may access the following types of electronic health information through Rochester RHIO for research purposes. This includes information created before and after the date of this Consent Form. [Name of Provider Organization's] researchers will only be permitted to use health information that is necessary for the research studies you have agreed to participate in. However, while locating this information and copying it into its own research database, [Name of Provider Organization's] researchers may gain incidental access to ALL of your electronic health information available through the Rochester RHIO. This information may relate to sensitive health conditions, including but not limited to:
 - Alcohol or drug use problems
 - Birth control and abortion (family planning)
 - Genetic (inherited) diseases or tests
 - HIV/AIDS
 - Mental health conditions
 - 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.

[Name of Provider Organization] will take reasonable steps to minimize any incidental access to your health information that is not required for the research studies.

- 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 [Provider Organization OR Rochester RHIO]. You can obtain an updated list of Information Sources at any time by checking Rochester RHIO's website at www.RochesterRHIO.org or by calling 1.877.865.7446.
- 4. Who May Access Information About You, If You Give Consent.** Only research staff employed by [Provider Organization] or outside researchers working at [Name of Provider Organization] who are involved in the research activities for which you have agreed to provide your information may access your information.
- 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 [Name of Provider Organization]; or visit Rochester RHIO's website at www.RochesterRHIO.org; or call the NYS Department of Health 877-690-2211.
- 6. Re-disclosure of Information.** Any electronic health information about you may be re-disclosed by [Name of Provider Organization] 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. Rochester RHIO and persons who access this information through the Rochester RHIO must comply with these requirements. You will not be identified in the published results of any research studies conducted with your information.
- 7. Effective Period.** This Consent Form will remain in effect until _____ or the day you withdraw your consent.
- 8. Withdrawing Your Consent.** You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to any of the researchers who are overseeing your medical care or [Provider Organization or Rochester RHIO]. You can get this form from any of [Name of Provider Organization's] researchers or on Rochester RHIO's website at www.RochesterRHIO.org; or by calling 1.877.865.7446. **Note: If [Name of Provider Organization's] researchers access your health information through Rochester RHIO while your consent is in effect, they may copy or include your information in their own research databases. Even if you later decide to withdraw your consent, [Name of Provider Organization's] researchers are not required to return your health information or remove it from these databases to the extent maintaining the information is necessary to complete the research study.**
- 9. Copy of Form.** You are entitled to get a copy of this Consent Form after you sign it.