ROCHESTER RHIO

Regional Health Information Organization

RHIO-WIDE DENIAL OF ACCESS FORM

Authorization to Deny Access to Patient Information
through a Health Information Exchange Organization

Patient Name	Date of Birth
Patient Address	

In completing this form, I request that health information regarding my care and treatment NOT be accessed by any health care providers and health plans through the Rochester RHIO, even in the event of an emergency.

The choice I make in this form will NOT affect my ability to get medical care.

☐ **I DENY CONSENT** for ALL Health Care Providers, Provider Organizations and/or Health Plans participating in the Rochester RHIO to access my electronic health information through the Rochester RHIO, even in a medical emergency.

My questions about this form have been answered and I have been provided a copy of this form. I understand that I have to complete and mail in this notarized form to the Rochester RHIO at 200 Canal View Blvd., Ste. 200, Rochester, New York 14623.

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)

(STATE OF NEW YORK, COUNTY OF _____) ss:

On this _____ day of _____, in the year _____, before me

personally came _____, to me known and known to me to be the person

described in and who executed the foregoing instrument in my presence.

NOTARY PUBLIC: _____