RHIO-WIDE CHANGE DENIAL OF ACCESS FORM

Change of RHIO-Wide denial of access to patient information
through a Health Information Exchange Organization

Patient Name	Date of Birth
Patient Address	

☐ **CHANGE OF RHIO-WIDE DENIAL OF CONSENT**. I previously denied consent to the release of health information to and by the Greater Rochester Regional Health Information Organization (Rochester RHIO) by signing a RHIO-WIDE DENIAL OF ACCESS form. I have changed my mind and would like to revoke (cancel) my RHIO-WIDE DENIAL OF ACCESS. By signing this Change of Global Consent form I am revoking my denial of access.

DATE OF CHANGE. This change will become effective when it is received by the Rochester RHIO and recorded in its health information exchange system.

VOLUNTARILY PARTICIPATION. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be denied because I grant or deny my consent to participate in the Rochester RHIO.

CHANGE OF RHIO-WIDE DENIAL OF ACCESS. I understand that if I participate in the Rochester RHIO, all of my medical information will be released by the Rochester RHIO to any hospital, physician or other health care provider that I may grant consent to access my information in the future.

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. I change my Denial of Access to participate in the Rochester RHIO.

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: _____