

**NYULMC HIE,  
CARE EVERYWHERE and HEALTHIX  
CONSENT FORM**

**Family Medicine, NYC, P.C.**



*Before signing the NYULMC HIE Consent Form below, please ensure that you have read the laminated NYULMC HIE Disclaimer Page*

*For detailed information please request for an HIE Information Sheet or call 212-404-4101.*

**This form has to be signed only once per practice.**

**PATIENT INFORMATION (PRINT CLEARLY)**

First Name

Last Name

Date of Birth (MM/DD/YYYY)

Patient ID/MRN

Please check Box 1 or 2:



**1. I GIVE CONSENT to ALL of the HIE Participants listed on the NYULMC HIE website and Care Everywhere Providers to access ALL of my electronic health information through the NYULMC HIE and I GIVE CONSENT to ALL employees, agents and members of the medical staff of NYU Hospitals Center to access ALL of my electronic health information through HEALTHIX in connection with any of the permitted purposes described in the fact sheet, including providing me any health care services, including emergency care.**

**2. I DENY CONSENT to ALL of the HIE Participants listed on the NYULMC HIE website and Care Everywhere Providers to access my electronic health information through the NYULMC HIE or HEALTHIX for any purpose, even in a medical emergency.**

**NOTE: UNLESS YOU CHECK THE "I DENY CONSENT" BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through the NYULMC HIE. IF YOU DON'T MAKE A CHOICE, the records will not be shared except in an emergency as allowed by New York State Law.**

Signature of Patient or Patient's Legal Representative

Today's Date (MM/DD/YYYY)

Print Name of Legal Representative (if applicable)

Relationship of Legal Representative (if applicable)