

**HEALTH INFORMATION EXCHANGE,  
CARE EVERYWHERE AND HEALTHIX  
CONSENT FORM**

In this Consent Form, you can choose whether to allow the health care providers listed on the NYU Langone Medical Center Health Information Exchange ("NYUL Health HIE") website <http://health-connect.med.nyu.edu/> ("HIE Participants") and non-NYU health care providers who may request access to your medical records for purposes of current treatment ("Care Everywhere Providers") to obtain access to your medical records through a computer network operated by the NYUL Health HIE. In order for a Care Everywhere Provider to know that information may be available through the NYUL Health HIE, you must tell them that you were/are a patient of an HIE Participant and that such information may be available upon request. This can help collect the medical records you have in different places where you get health care, and make them available electronically to the providers treating you.

You may also use this Consent Form to decide whether or not to allow employees, agents or members of the medical staff of NYU Hospitals Center to see and obtain access to your electronic health records through Healthix, which is a Health Information Exchange, or Regional Health Information Organization (RHIO), a not-for-profit organization recognized by the state of New York. This can also help collect the medical records you have in different places where you get healthcare, and make them available electronically to the providers treating you. This consent also gives your permission for any NYU Langone Health program in which you are a patient or member, to access your records from your other healthcare providers authorized to disclose information through Healthix. A complete list of current Healthix Information Sources is available from Healthix and can be obtained at any time by checking the Healthix website at <http://www.healthix.org> or by calling Healthix at 877-695-4749. Upon request, your provider will print this list for you from the Healthix website.

**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.**

The NYUL Health HIE and Healthix share 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 your health care provider for it, or go to the website [www.ehealth4ny.org](http://www.ehealth4ny.org).

**PLEASE CAREFULLY READ THE INFORMATION ON THE FACT SHEET BEFORE MAKING YOUR DECISION.**  
Your Consent Choices. You can fill out this form now or in the future. You have the following choices:

Please check one box  below:

1. I GIVE CONSENT to ALL of the HIE Participants listed on the NYUL Health HIE website and Care Everywhere Providers to access ALL of my electronic health information through the NYUL Health 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 NYUL Health HIE website and Care Everywhere Providers to access my electronic health information through the NYUL Health 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 NYUL Health 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.**

JEFFREY EPSTEIN  
PRINT Name of Patient

1-20-1953  
Patient Date of Birth

\_\_\_\_\_  
Signature of Patient or Patient's Legal Representative

7-11-18  
Date

\_\_\_\_\_  
Print Name of Legal Representative (if applicable)

\_\_\_\_\_  
Relationship of Legal Representative to Patient (if applicable)