HIE-wide Consent Form

I, _____, deny all Provider Organizations and Health Plans participating in HealtheConnections to access my electronic health information through HealtheConnections.

_____
Patient Signature

_____
Date

_____
Witness Name

_____
Witness Signature

Return a copy of this form to support@hiemail.healtheconnections.org or fax to 315.407.0053

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Connecting You to Better Care