CONSENT TO SHARE PERSONAL HEALTH INFORMATION

By enrolling in the Boca HealthLink Program, you will receive continuity of care for all your medical needs whether you are in Florida or New York. By signing this Consent Form, you will allow Northwell Health healthcare service providers and Boca Raton Regional Hospital and its providers to access and disclose your medical information to the other institution and its providers. This will allow your providers in New York and in Florida to share your medical information and have access to your medical records maintained in different places in order to enable these providers to have your most current medical information and to provide you with the best care possible. If you choose to check "I GIVE CONSENT" and sign this Consent Form, any Northwell Health or Boca Raton Regional Hospital provider or program in which you are a patient or member, will be able to obtain access to, and share your medical information related to your treatment and medical needs.

Please indicate your consent by initialing the "I Give Consent" box below and signing at the bottom of this page. If you choose not to give consent, your choice will not affect your ability to get medical care or health insurance coverage and will not be the basis for denial of health services. You may revoke this consent at any time by providing written notice to _____. If you do not revoke this consent, it will continue for a period of five years.

Please indicate your consent by initialing the box and signing below:

☐ **I GIVE CONSENT**
By initialing and signing this form, you are saying "Yes, Northwell Health and Boca Raton Regional Hospital's providers and staff involved in my care may see and get access to all of my medical records, including but not limited to HIV/AIDS, mental health, genetic testing information and substance abuse records through an electronic transfer of information or by paper." Some State and Federal laws provide special protections for HIV/AIDS, mental health, substance abuse and genetic testing. These special requirements must be followed whenever people receive these kinds of sensitive health information.

_____	_____
Signature of Patient or Patient's Legal Guardian	Date
_____	_____
Printed Name of Patient	Patient Date of Birth
_____	_____
Print Name of Legal Representative (if Applicable)	Relationship of Legal Representative to Patient (if applicable)