PSYCKES CONSENT FORM

In the Consent Form, you can choose whether to allow your provider to obtain access to your MEDICAID medical records electronically through PSYCKES. This can help coordinate all the different types of health services you have received through MEDICAID and make them available electronically to this provider.

You may use this Consent Form to decide whether or not to allow this provider to see and obtain access to your electronic health information in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. 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.**

If you check the "**I GIVE CONSENT"** box below, you are saying "Yes, this provider's staff involved in my care may see and get access to all of my medical information through PSYCKS"

If you check the "**I DENY CONSENT"** box below, you are saying "No, this provider may not see or be given access to my medical information through PSYCKES," THIS DOES NOT MEAN YOUR PROVIDER IS COPLETELY BARRED FROM ACCESSING YOUR MEDICAL INFORMATION IN ANY WAY. FOR EXAMPLE, IF THE MEDICAID PROGRAM HAS A QUALITY CONCERN ABOUT YOUR HEALTHCARE, THEN UNDER FEDERAL AND STATE REGULATIONS YOUR PROVIDER MAY BE GIVEN ACCESS TO YOUR DATA TO ADDRESS THE QUALITY CONCERN. THERE ARE ALSO EXCEPTION TO THE CONFIDENTIALITY LAWS THAT MAY PERMIT YOUR PROVIDER TO OBTAIN NECESSARY INFORMATION DIRECTLY FROM ANOTHER PROVIDER FOR TREATMENT PURPOSES UNDER STATE AND FEDERAL LAWS AND REGULATIONS.

Please carefully read the information on the back of this form before making your decision.

Your **Consent Choices**. You can fill out this form now or in the future. You have two choices.

- □ **I GIVE CONSENT for this provider to access ALL** of my electronic health information through PSYCKES in the connection with providing me any health care services.

- □ **I DENY CONSENT for this provider to access** my electronic health information through PSYCKES; however, I understand that my provider may be able to obtain my information even without my consent for certain limited purposes if specifically authorized by the state and federal laws and regulations.

_____	_____	_____
Print Name of Patient	Date of Birth of Patient	Patient's Medicaid ID #
_____	_____	
Signature of Patient or Patient's Legal Representative	Date	
_____	_____	
Signature of Witness	Print name of Witness	