

Joining the new ICS Health Home program is really easy! Here's how to fill out the consent form:

1 I AGREE to be in the Independence Care System Health Home and agree that the Health Home can get ALL of my health information from the partners listed at the end of this form and from others through NY Care Information Gateway RHIO and/or through PSYCKES and/or through TABS/CHOICES to give me care or manage my care, to check if I am in a health plan and what it covers, and to study and make the care of all patients better. I also AGREE that the Health Home and the partners listed at the end of this form may share my health information with each other. I understand this Consent Form takes the place of other Health Home Patient Information Sharing Consent Forms I may have signed before to share my health information. I can change my mind and take back my consent at any time by signing a Withdrawal of Consent Form (DOH-5058) and giving it to one of the Health Home partners.

2 **Print your name here.** Print Name of Patient
Enter your date of birth. Patient Date of Birth
Sign your name here. Signature of Patient or Patient's Legal Representative
Enter today's date. Date
Print Name of Legal Representative (If Applicable) Relationship of Legal Representative to Patient (If Applicable)

(Bottom of page 1)

(Top of page 3)

Independence Care System Participating Partners
Health Home Name

3 **Put your initials here.** **Enter today's date.**
Patient Initials Date

Independence Care System
Name of Participating Partner
VNSNY CHOICE
Name of Participating Partner
NY Care Information Gateway
Name of Participating Partner

4 **Write the names of providers who you want ICS to share information with.**
Name of Participating Partner
Name of Participating Partner
Name of Participating Partner

1. Check the box.

On page 1, check where it says “I AGREE to be in the Independence Care System Health Home.”

2. Enter your information.

Also on page 1, print your name, date of birth, the date signed and sign your name where it says “Signature of Patient or Patient’s Representative.”

3. Write your initials.

At the top of page 3, write your initials where it says “Patient Initials.”

4. Add your providers.

Also on page 3, write the names of providers who you want ICS to share information with in order to help you stay healthy. You can list as many providers as you wish, but you must list at least one. For example this could be your primary doctor or specialist or someone else who provides you with care.

5. Send it in!

Give the form to an ICS staff member, or mail it to ICS in the prepaid envelope provided. You can also email it to MSCDocMgt@icsny.org or fax it to 718.907.1670.