Permission to Communicate my Health Information Electronically

Our office is pleased to inform that we now participate in a health information exchange. As you may be aware, health information exchanges allow for electronic communication and access to your electronic medical record. This electronic access, in turn, supports opportunities for improved continuity of care by physicians and other healthcare personnel who are involved in your care. Most important is that health information exchanges create a means by which healthcare data may be accessed in a shorter period than has been traditionally the case with paper records.

Participation in the health information exchange could give your healthcare provider access to critical information such as your home address, past medical history, surgical history, hospitalizations, family history, social history, vital signs, immunizations, allergies, chronic medical conditions, previous and current medications, laboratory and radiology test results. Of course, your privacy protections through HIPAA would remain and providers will be expected to access information consistent with these rules.

PLEASE INDICATE YOUR CHOICE TO PARTICIPATE OR NOT IN THE EXCHANGE AS PROVIDED FOR BELOW

_____**YES**, I want to **participate to communicate my health information with healthcare professionals involved in my healthcare through the health information exchange.** I have been informed about information that will be communicated and have had the opportunity to as any questions about this decision. I understand that I have the right to change my mind and can withdraw permission by updating this form by checking NO section and entering a revised date. If I withdraw permission, any information in my electronic medication record will not be accessible by the health information exchange. At that point, my doctor will still be able to communicate my information by the standard methods of telephone, fax, U.S mail, and encrypted mail.

_____**NO, I do not (or no longer) want to participate to communicate my health information with healthcare professionals involved in my healthcare through the health information exchange.** I have had the opportunity to ask any questions about this decision. I understand that my information will continue to be stored in my electronic medical record but will not be accessible by the health information exchange. I understand that by not participating it may be more difficult for physicians and other healthcare providers to coordinate my care especially in an emergency situation or when my physician is not available. My physician will still be able to communicate my information by the standard methods of telephone, fax, U.S mail, and encrypted mail.

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Print First Name, Last Name, DOB

_____ _____

Signature of Patient or Representative Date

Rx History Consent

I give **permission for my provider to access my pharmacy benefits data electronically through RxHub.** This consent will enable my provider to: determine the pharmacy benefits and drug co-pays for a patient's health plan, check whether a prescribed medication is covered (in formulary) under a patient's plan, display therapeutic alternatives with preference tank (if available) within a drug class for non-formulary medications, determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies, download a historic list of all medications prescribed for a patient by an provider.

Patient or Representative Signature _____Date_____