CovenantHealth

HIE Opt-In Consent Form

This form is to be used by patients who **want** to participate in the Health Information Exchange (HIE)

Providence St. Joseph Health's Health Information Exchange ("PSJH HIE") allows you to permit your health information to be shared by participating medical groups, hospitals, labs, radiology centers, and other health care providers through secure, electronic means. The purpose of the PSJH HIE is to give each of your participating providers the benefit of having access to all of your health information that is maintained by the participating providers when providing healthcare to you.

Your participation in the PSJH HIE is voluntary and your receipt of treatment or health plan coverage for treatment will not be conditioned on whether or not you sign this form. **REGARDLESS OF WHETHER OR NOT YOU SIGN THIS FORM, INFORMATION RELATED TO CARE THAT YOU HAVE RECEIVED AT A PROVIDENCE ST. JOSEPH HEALTH SYSTEM, COVENANT HEALTH SYSTEM, OR HOAG HOSPITAL FACILITY WILL BE ACCESSIBLE THROUGH THE PSJH HIE FOR TREATMENT PURPOSES TO ALL PARTICIPATING PROVIDERS WHO PROVIDE YOU WITH CARE;** however, such information will not otherwise be disclosed by the PSJH HIE and no non-hospital health information will be accessible through the PSJH HIE. You should be aware that depending on your providers' technical capabilities, even if you do not sign this form, your health information may still be disclosed to the PSJH HIE, but the PSJH HIE will not permit it to be viewed, except as described above related to hospital health information.

By signing this form I hereby ACKNOWLEDGE and AGREE as follows:

1. My health care providers that participate in the PSJH HIE may disclose my health information to the PSJH HIE and my health information may be shared with all health care provider participants of the SJH HIE that are involved in my care. The PSJH HIE may also share my health information with members of other health information exchanges to which the PSJH HIE connects who are involved in my care.
2. My health information that will be shared through the PSJH HIE will include health information from both before and after today's date and may include information related to treatment I received from any provider who is connected, either directly or indirectly, to the PSJH HIE, including out-of-state providers. For example, if I have received care at a Providence St. Joseph Health System facility in California, my information related to that care will be included in the PSJH HIE, even if I reside or sign this form in Texas and even if I previously opted-out of the PSJH HIE by signing the proper opt-out form.
3. My health information that will be shared through the PSJH HIE includes information about my diagnoses, test results (like x-rays or laboratory), and medications that have been prescribed to me. Such information may also include health information that may be considered particularly sensitive to me, including:
   - Mental health information
   - HIV/AIDs information and test results
   - Genetic information and test results
   - STD treatment and test results
   - Family planning information
4. My health information that is made available to the PSJH HIE may be used by PSJH HIE participants for treatment purposes. The PSJH HIE may further use my health information and make it available

to other health information exchanges and their participants, for treatment, payment, and health care operations activities; however, such disclosures by the PSJH HIE to another health information exchange will only be permitted in accordance with applicable law and information that is disclosed will not include HIV test results, mental/behavioral health records, and genetic/hereditary test results.

5. Health care providers who receive health information about me through the PSJH HIE may copy or include my health information into their own medical records when caring for me. If I cancel this consent, such cancellation will have no effect on the health information such providers already accessed and copied.

6. I understand that this consent will remain in effect until I cancel it. I may cancel this consent by completing the Providence St. Joseph Health "Revocation of HIE Opt-In Request Form" and submitting the completed form to the address provided on the form or to Admissions, Registration or Front Office staff at a Providence St. Joseph Health facility.

7. It may take between **2 - 5 business days after receipt** to process my consent and for the PSJH HIE to make my information available for sharing through the PSJH HIE.

8. I have a right to ask for a copy of this form after I sign it.

Please select one*: **I am the Patient** **I am the Legal Representative of the Patient**

Patient's Name: Last *	First*	Middle Initial
Previous Name or Nicknames:	Patient's Date of Birth:*	Primary Phone Number: *
Email:	Sex (M/F):	Secondary Phone Number:
Postal Address:*	City:*	State:* Zip:*

*required information

Signature of Patient (or Legal Representative) **Date Signed**

If under 18 years, signature of Parent or Guardian

Legal Representative Name * Legal Representative Relationship to Patient* Legal Representative Phone # *

Mail:
PSJH Health Information Exchange (HIE) Division
c/o: Director of Health Information Exchange (HIE)
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