CHIE Patient Consent & Change Form *Please return this Patient Consent to your authorized healthcare provider.*

THE CLINICAL HEALTH INFORMATION EXCHANGE (cHIE) IS HERE TO MAKE YOUR LIFE SIMPLER AND SAFER. With this form, you choose whether to allow your medical information to be stored and accessed through a statewide electronic system called the cHIE. If you choose to participate in the cHIE, the cHIE will collect your medical information from the different places you receive healthcare. This helps in giving you the best care possible.

THE POWER OF SHARING.

PATIENT INFORMATION (PLEASE PRINT):

Full Name:

_____

(Last) (First) (Middle)

Date of Birth: _____

Gender: ___Male ___Female

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Numbers:

Home: _____ Mobile: _____ Work: _____

Email Address: _____

CONSENT OPTIONS (PLEASE CHOOSE ONLY ONE BOX BELOW):

- ☐ PARTICIPATE: I give consent to share and allow access to my medical records to participating healthcare professionals through the cHIE.
- ☐ LIMITED: I give consent to share and allow access to my medical records to participating healthcare professionals through the cHIE only in an emergency or only for this medical visit.
- ☐ NOT-PARTICIPATE: I do not want my medical records accessed by any healthcare professional through the cHIE, even in an emergency.

You can change your consent at any time by going to a participating cHIE healthcare professional and requesting a change. Changes made to consent will be processed in a reasonable amount of time, and may not be immediate. Your current consent status will remain until your request can be updated.

By signing this form, I acknowledge that I have read and understand my consent options as described herein. I also understand I can change my consent at any time by completing a new cHIE Patient Consent Form and returning it to a participating cHIE Healthcare professional.

_____ _____

SIGNATURE OF PATIENT OR PATIENT'S LEGAL REPRESENTATIVE DATE OF CONSENT DECISION

REQUIRED - CONSENT WITNESSED BY AUTHORIZED AGENT To protect your privacy and verify your identity, your signature on this consent form must be witnessed by your healthcare professional or a cHIE representative.

Name of Organization: _____Name of Witness:_____

As a witness to this Consent, I attest that the above signer is personally known to me or has established his/her identity with me by satisfactory photo ID, insurance card, or other evidence of identity customarily relied upon in healthcare.