Santa Cruz HIE Patient Consent

Santa Cruz Health Information Exchange (Santa Cruz HIE) is a community information system that helps healthcare providers securely share medical records. Santa Cruz HIE enables authorized medical professionals and support staff involved in your care to quickly access the information they need to provide you with the best care.

Sharing of your Electronic Medical Records provides many benefits to you, physicians and other providers. Tracking and management of your Electronic Medical Records is much easier. In the event of an emergency or disaster, your health care records can be retrieved by authorized health care professionals to ensure the best possible care and treatment plan for you.

By consenting to participate in Santa Cruz Health Information Exchange I understand the following:

I authorize Santa Cruz HIE to share my personal health information with other participating health care providers, including physicians, clinics, hospitals, other licensed providers, and health insurers. If I sign this form as the Patient's Legal Representative, I understand that all references in this form to "me", "my", or "I" refer to the patient.

My health information will be shared ONLY for the purpose of medical treatment by my health care provider(s).

The types of information included in my Medical Record include but are not limited to are; Emergency room records, hospital records, nursing notes, laboratory results, pathology reports, x-ray reports, images, and all other personal health information. Information about me may only be disclosed to the extent permitted by applicable laws and regulations. Certain other types of information, such as mental health or substance abuse, may not be shared without my additional consent.

This Authorization permits access to personal health information created both after and before the date I sign this form.

The decision to participate in Santa Cruz HIE is voluntary and no health care provider participating in the Santa Cruz HIE will deny treatment and my insurance eligibility will not be affected if I choose not to participate. My health information will still be available to be shared as permitted by law. My health insurer(s) will continue to have access to my medical records for disease management, case management, and quality improvement purposes.

I have the right to change my decision by completing a form and submitting to my provider. Any information shared prior to revocation of consent will not be affected and cannot be removed. I understand in the event of an Emergency, authorized health care providers participating in Santa Cruz HIE will have the rights to access my Medical Record regardless of my decision to participate in Santa Cruz HIE. My provider(s) will continue to store my health information in his/her electronic medical record.

I recognize that state and federal privacy laws allow the State of California, particularly the Department of Public Health, to have access to my personal and health information for the purpose of public health activities according to state laws and regulations and prohibits the sale of patient information for commercial marketing purposes, regardless of my decision to participate in Santa Cruz HIE.

I understand that I have the right to request a copy of any of my Medical Records used or disclosed by the Santa Cruz HIE as a result of the consent to participate. A list of participating Santa Cruz HIE health care providers and other organizations is available by going to: www.santacruzhie.org.

I have reviewed the above information and herby authorize and consent to allow Santa Cruz HIE to release and provide access of my Medical Records to my health care providers, health insurers, and other Santa Cruz HIE participants. I understand I may revoke my consent at anytime and my consent remains in effect until the day I change my consent or Santa Cruz HIE is no longer in operation, whichever comes first. I have been offered a copy of the Notices of Privacy Practices.

Patient Name	Patient Date of Birth	Date of Signature

Signature of Patient or Patient's Legal Representative	Relationship to patient (parent, guardian)

Participating provider where this Authorization was signed: _____