LA MAESTRA COMMUNITY HEALTH CENTERS
City Heights · El Cajon · National City · Lemon Grove

# Patient Consent Form for Electronic Exchange of Individual Health Information (HIE)

*PLEASE READ BOTH SIDES OF THIS DOCUMENT*

**CONSENT**
Signing the consent form means that you are allowing your own electronic health information to be used by health care providers at participating centers and clinics **only** to provide you with medical treatment and support public health projects.

Sharing your own electronic health information in a health information exchange is your choice. The health care providers will provide you with medical care even if you decide not to share your own electronic health information in the health information exchange. Your insurance eligibility will not change based on your decision to share your own electronic health information in the health information exchange.

**PURPOSE**
Sharing your own electronic health information will allow your health care provider to review all of your medical history and treatments. This will help your health care provider to make better informed decisions about your medical care.

Some benefits of sharing individual health information electronically may be:
- Improved communication among your health care providers, and
- Fewer unneeded tests and treatment.

Some risks of sharing your own health information electronically may be:
- Someone seeing your individual health information who is not providing you with medical treatment or supporting public health projects, and
- Someone stealing your health information by entering the health information exchange illegally.

**TYPES OF INFORMATION INCLUDED IN THIS CONSENT**
If you give consent, any participating HIE organization may view and share ALL of your electronic health information available through any connected health information exchange. This includes information created before and after the date of your consent form. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like x-rays or blood tests), and medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:

- Alcohol or substance abuse records
- Birth control, abortion and family planning
- Inherited or genetic conditions
- HIV
- Mental health conditions
- Sexually transmitted diseases
- Lab results

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***My Consent Choices (CHECK ONE):***

☐ **I GIVE CONSENT FOR** participating healthcare sites to share my unrestricted electronic health information through health information organization(s) who provide me any health care services, including emergency care.

☐ **I DENY CONSENT FOR** participating healthcare sites to share any of my unrestricted electronic health information through health information organization(s) EXCEPT in the event of a medical emergency.

☐ **I DENY CONSENT FOR** participating healthcare sites to share any of my electronic health information through health information organization(s) EVEN in the event of a medical emergency.

***Signature of patient or authorized representative:***
If I sign this form as the Patient's Authorized Representative, I understand that all references in this form to "I", "me" or "my" refer to the Patient.

_____ _____
*Signature* *Date*

If signed by someone other than the patient, print name and indicate relationship:

_____ _____ _____
*Authorized Representative* *Relationship* *Date*

Address of authorized representative signing this form (please print):

_____
*Street Address/PO Box* *City* *State* *Zip code*

Phone number of authorized representative signing this form: __ __ __ - __ __ __ - __ __ __ __

***Signature of witness:***
Witness required only for telephone consent, physical inability to sign, or signature by mark. Telephone consent is subject to verification of identity.

_____ _____ _____
*Witness* *Relationship* *Date*