

Health Information Exchange (HIE) Consent

I, _____ the undersigned, hereby give my informed consent for the release and exchange of my protected health information (PHI) through the Health Information Exchange (HIE) system, as described below:

Purpose of the HIE: The Health Information Exchange (HIE) is a secure electronic system that allows healthcare providers, such as hospitals, clinics, and healthcare professionals, to access and share my health information for the purpose of providing me with better healthcare services, improving the coordination of my care, and enhancing the quality and safety of my medical treatment.

Information to be Shared: I understand that the following types of health information may be shared through the HIE:

Medical history
Medications
Allergies
Laboratory results
Radiology reports
Immunization records
Hospital discharge summaries
Physician progress notes
Other relevant health information
Authorized Recipients:

Recipients: I understand that the authorized recipients of my health information through the HIE may include but are not limited to:

Hospitals
Physicians
Pharmacists
Laboratories
Radiology centers
Emergency medical services (EMS)
Health plans
Rights and Acknowledgment:

Patient Rights and Responsibilities Regarding HIE:

- I have the right to revoke this consent at any time by providing written notice to my Provider.
- My healthcare providers may access my health information through the HIE without my consent in certain emergency situations.
- I have the right to request an audit trail of who accessed my health information through the HIE.
- I understand that the HIE has security measures in place to protect the confidentiality of my health information.

Expiration and Duration: This consent for the exchange of health information through the HIE will remain in effect until I revoke it in writing or until my healthcare providers are no longer participating in the HIE.

Patient's Consent: I have read and understand the information provided in this consent form. I voluntarily consent to the exchange of my health information through the Health Information Exchange (HIE) as described above.

Signature of Patient or Patient's Representative

Date

Printed Name

Representative's Relationship to Patient

Provider's Acknowledgment: I hereby confirm that I have discussed the Health Information Exchange (HIE) with the patient and obtained their informed consent as indicated above.

Signature of Provider

Date

Printed Name of Provider

