Specially Protected Health Information Authorization Form

____YES. I authorize this practice to use and/or disclose a copy of my specially protected health information in the Electronic Health Information Exchange (eEHX) for the purpose of coordinating my medical care amongst my healthcare providers. I understand that including this information in eEHX enables any provider with authorized access to the eEHX to review my protected health information, including the following specially protected health information:

I acknowledge that I have been given sufficient information and have had the opportunity to have my questions answered about the Electronic Health Information Exchange (eEHX).

I understand that future withdrawal of permission to include this information in the Electronic Health Information Exchange (eEHX) will be effective except to the extent action has already been taken in reliance on this permission. When I withdraw permission my specially protected health information will be inactivated and the eEHX and will no longer be able to be accessed. This permission will expire if the eEHX program is discontinued.

I understand that my eligibility for treatment or any health care benefits cannot be conditioned on whether I sign this authorization form. However, to the extent I have indicated "YES" to the sharing of my protected health information, I understand that an electronic Health Information Exchange record will be available to other eEHX authorized users.

_____

Authorized date(s) or date range

_____

Printed Name of Patient/Representative

_____ _____

Signature of Patient/Representative Date

AUTHORIZATION OF REPRESENTATIVE:

I,_____, do hereby state that I an authorized to sign this permission on behalf of the patient on the following basis:

Relationship to Patient _____

[A signed copy of this permission will be provided to the patient/representative]