Camden Coalition

HEALTH INFORMATION EXCHANGE

CONSENT FOR MY HEALTHCARE PROVIDER TO VIEW MY HEALTH INFORMATION IN THE CAMDEN HEALTH INFORMATION EXCHANGE

Healthcare Provider(s): _____

This Consent form allows you to permit the above-named healthcare provider(s) ("Provider") to view and access your health information through a computerized system called the Camden Health Information Exchange ("Camden HIE").

The Camden HIE collects health information from the places where you receive medical treatment and makes it available electronically to the Provider listed above. Your health information in the Camden HIE is used by the Provider for your medical treatment and to coordinate your medical care with other healthcare providers.

If you give your consent, the Provider will be able to view all of your health information in the Camden HIE for this episode of care, which is defined as a period of six (6) months.

You can give Consent or deny Consent. Your Provider cannot tell you that you must give Consent in order to receive medical treatment. You may stop the Provider from viewing your health information through the Camden HIE at any time.

Please read the information on the back of this form before making your decision.

Your Consent choices (*initial only one)*:

_____ **I GIVE CONSENT** for the Provider named above to access ALL of my health information through the Camden HIE for the purpose of providing me with health care services, including emergency care.

_____ **I DENY CONSENT** for the Provider named above to access my health information through the Camden HIE for any purpose, even in a medical emergency, unless the law specifically permits it without my consent.

_____ _____

Patient Name (Print) Patient Date of Birth (mm/dd/yyyy)

_____ _____

Patient Signature Date

The patient is an unemancipated minor or is unable to complete this Consent form due to a medical emergency, unconsciousness, incompetency, etc.; therefore, the above consent decision was made on behalf of the patient by:

_____ _____

Name (please print) Date/Time

_____ _____

Signature Relationship to Patient

PLEASE READ these details about the Camden HIE and your consent:

1. **How your health information will be used**: Your health information will be used by your Provider to:
    - Provide you with medical treatment and related services
    - Coordinate your medical care with other healthcare providers
    - Improve the quality of medical care you receive

2. **What types of information about you are included**: Your health information 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 lists of medications you have taken. This includes information created before and after the date of this Consent Form. Sensitive health conditions may also be included, such as:
    - Alcohol or drug use problems
    - Birth control, abortion, family planning
    - Genetic (inherited) diseases or tests
    - HIV/AIDS
    - Mental health conditions
    - Sexually transmitted diseases

3. **Where health information about you comes from**: Health information about you comes from places that have provided you with medical care. These include: hospitals, physicians, pharmacies, laboratories, the Medicaid program, nursing care services, emergency medical services, and other health organizations that provide information to the Camden HIE. The Camden Coalition of Healthcare Providers (www.camdenhealth.org) can provide you with a complete list of organizations that send health information to the Camden HIE.

4. **Who may access information about you, if you give Consent**: Only authorized people that work for the Provider may access information about you through the Camden HIE. These include, but are not limited to:
    - Doctors and other medical and non-medical staff directly involved in your medical care
    - Doctors and other medical and non-medical staff on call or covering for your doctor and directly involved in your medical care

5. **Penalties for improper use or access of your health information:** There are penalties for wrongful access to or use of your health information through the Camden HIE. If at any time you suspect that someone who should not have seen or gotten access to your health information has done so, contact the Provider listed on this form or the Camden Coalition of Healthcare Providers (856-365-9510) immediately.

6. **Re-disclosure of information**: Health information about you may be re-disclosed by the Provider to others only to the extent permitted by state and federal laws and regulations. The Camden Coalition and healthcare providers who access this information through the Camden HIE must comply with these regulations.

7. **Effective period:** This Consent Form will remain in effect for six (6) months of your medical care.

8. **Withdrawing your consent**: You may withdraw your consent at any time by signing a new Consent Form. Providers that have accessed your health information through the Camden HIE while your consent was in effect may copy or include your health information in their own medical records. If you decide to withdraw your consent, those providers are not required to return or remove your health information from their records.

9. **Copy of Consent Form**. You are entitled to get a copy of this Consent Form after you sign it.

The Camden Coalition of Healthcare Providers is a non-profit organization with the mission to "…improve the quality, capacity, and accessibility of the health system for all Camden residents."