PATIENT REQUEST FOR EXEMPTION FROM PARTICIPATION IN ELECTRONIC HEALTH INFORMATION EXCHANGE

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Section A:

Patient name (last, first, middle): _____

Address: _____

SHC/UHA Medical Record Number (if known): _____ Date of Birth: _____

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Section B: SECURE ELECTRONIC HEALTH INFORMATION EXCHANGE

Secure electronic exchange of health information helps ensure better care and coordination of care. The Stanford Hospital & Clinics (SHC) and the University Healthcare Alliance (UHA) participate in health information exchange(s) that allow outside providers who need information to treat you to request and receive your health information through secure electronic health information exchange. For example, your non-SHC or non-UHA health care providers will be able to request and receive a summary of your allergies, medications, tests, and other clinical information which may not otherwise be readily available to them in your non-SHC or UHA medical records.

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Section C: Request for Exemption from Participation in ELECTRONIC Health Information Exchange

I do not wish to participate in the release of my medical information from SHC or UHA via secure health information exchange to my non-SHC or non-UHA health care providers for my care management and treatment. I understand that by honoring this request, SHC and UHA will not share my health information to my other providers via secure electronic health information exchange, except as otherwise authorized under State and Federal patient health information privacy laws.

I understand that my request to be exempted from the secure electronic health information exchange does not affect my non-SHC or non-UHA health care provider's ability to otherwise obtain my SHC or UHA health information through other approved release of information procedures.

I understand that by signing this request, my non-SHC and non-UHA health care providers may not receive automatic notification via the secure electronic health information exchange system about my care provided by SHC or UHA for continuity of care purposes.

I understand that my signed request becomes effective upon receipt and processing and will remain effective until and unless I request this to be changed. I understand that should I wish to rescind my request for exemption from secure electronic health information exchange to non-SHC or non-UHA health care providers, I must submit my request in writing to Stanford Hospital & Clinics, Health Information Management Services (HIMS) Department, 450 Broadway St. Room C14, MC5200, Redwood City, CA 94063, or fax to (650) 498-5120.

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Section D: INFORMATION YOU SHOULD KNOW BEFORE SIGNING

If you have questions about this form or the release of your health information, please contact the SHC HIMS Department at 650-723-5721 before signing.

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Section E:

By my signature dated below, I hereby request that Stanford Hospital and Clinics (SHC) and University Healthcare Alliance (UHA), do not release my health information via secure electronic health information exchange to non-SHC and non-UHA health care providers as described in Section C above.

Name of patient (please print):

_____

Name of legal representative signing this form, if applicable (please print):

_____

Address of patient or legal representative signing this form (please print):

_____

Phone number of patient or legal representative signing this form (please print):

_____

If you are not the patient and you are signing this form, describe your authority to sign on behalf of the patient and provide supporting legal documentation:

_____

Personal Representative's Name (print) and Relationship

Signature of patient or legal representative: _____ *Date:* _____

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Section F: PATIENT REQUEST TO RESCIND EXEMPTION FROM PARTICIPATION IN ELECTRONIC HEALTH INFORMATION EXCHANGE

By my signature dated below, I hereby notify Stanford Hospital and Clinics (SHC) and University Healthcare Alliance (UHA), that I allow release of my SHC or UHA health information via secure electronic health information exchange to my non-SHC or non-UHA health care providers as allowable by law.

Name of patient (please print):

_____

Name of legal representative signing this form, if applicable (please print):

_____

Address of patient or legal representative signing this form (please print):

_____

Phone number of patient or legal representative signing this form (please print):

_____

If you are not the patient and you are signing this form, describe your authority to sign on behalf of the patient and provide supporting legal documentation:

_____

Personal Representative's Name (print) and Relationship

Signature of patient or legal representative: _____ *Date:* _____

***A COPY OF THIS FORM MUST BE GIVEN TO THE PATIENT ***