SHRINERS HOSPITALS FOR CHILDREN®
Opt-In SHC HIE Consent

Shriners Hospitals for Children's Health Information Exchange ("SHC HIE") is a way of allowing your health information to be shared by participating medical groups, other healthcare providers of your choosing, through secure, electronic means. The purpose of the SHC HIE is to give each of your participating providers the benefit of having access to your health information that is maintained by SHC when providing healthcare to you.

Your participation in the SHC HIE is voluntary, and your receipt of treatment or payment for treatment will not be conditioned on whether or not you sign this form.

By signing this form, I hereby ACKNOWLEDGE and AGREE as follows:

1. SHC HIE may disclose my health information to the SHC HIE and my health information may be shared with designated healthcare providers that are involved in my care.
2. My health information that will be shared through the SHC HIE will include health information from both before and after today's date. My health information that will be shared through the SHC HIE includes information about my diagnoses, test results (like x-rays or laboratory), and medications that have been prescribed to me. Such information may also include health information that may be considered particularly sensitive to me, including:
    - Mental health information
    - HIV/AIDs information and test results
    - Genetic information and test results
    - STD treatment and test results
    - Family planning information
3. Healthcare providers who receive health information about me through the SHC HIE may copy or include my health information into their own medical records when caring for me. If I cancel this consent, such cancellation will have no effect on the health information such providers already accessed and copied.
4. I understand that this consent will remain in effect until I cancel it. I may cancel this consent by requesting and completing the "SHC Health Information Exchange Opt-In Cancellation Request Form" and submitting the completed form to my local Shriners' Hospital.
5. It may take **several business days after receipt** to process my consent and for the SHC HIE to make my information available for sharing through the SHC HIE.
6. I have a right to ask for a copy of this form after I sign it.

Patient's Name: Last*	First*	Middle Initial
Previous Name or Nicknames:	Patient's Date of Birth:*	Primary Phone Number:* ( ) -
Email:	Sex (M/F):	Secondary Phone Number: ( ) -
Address:*	City:*	State:* Zip:*

*required information

Opt-In HIE Consent
Shriners Hospitals for Children®

Patient Information Label

* H I E 1 *

SHRINERS HOSPITALS FOR CHILDREN®
OPT-IN SHC HIE CONSENT

I hereby authorize Shriners Hospitals for Children® to disclose to:

Practice Name:*			
Physician's Name:*			
Address:*	City:*	State:*	Zip:*
Email:	Phone Number:*	Fax Number:	

Practice Name:*			
Physician's Name:*			
Address:*	City:*	State:*	Zip:*
Email:	Phone Number:*	Fax Number:	

* Required Fields

Patient Signature or Legal Representative: _____ **Date Signed:** _____ **Time:** _____
(If under age 18 years, signature of parent or legal guardian)

Witness Signature: _____ **Date Signed:** _____ **Time:** _____

OPT-IN HIE CONSENT
Shriners Hospitals for Children®

Patient Information Label