SHRINERS HOSPITALS FOR CHILDREN®
SHC HIE INFORMATION REQUEST

Please complete this form to be granted access to your patients' information via our SHC HIE portal.

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

Health information that will be shared through the SHC HIE will include information about the patients' diagnoses, test results (like x-rays or laboratory), and medications that have been prescribed while under SHC care. Such information may also include health information that may be considered particularly sensitive, including:

- Mental health information
- HIV/AIDs information and test results
- Genetic information and test results
- STD treatment and test results
- Family planning information

Our patient's participation in the SHC HIE is voluntary, and their receipt of treatment or payment for treatment will not be conditioned on whether or not you choose to utilize the HIE or complete and return this form. If the patient, in the future, chooses to cancel their consent, such cancellation will have no impact on the health information such providers already accessed and copied.

In order to set up access to the patient's medical information we will need to associate the practice to a unique organization identification (OID) value. If the Physician practice has obtained an OID via the HL7.org website please provide the OID below. If an OID has not been obtained, SHC will assign a generic number which will only be used within the SHC HIE system. Future expansion of the SHC HIE may necessitate the practice obtaining an OID via the HL7.org website in the future.

Once access to SHC HIE has been set up, the Physician identified below will be provided with logon information and agrees not share to such logon information with others, in order to protect the privacy of their patient.

I HEREBY ACKNOWLEDGE THE ABOVE INFORMATION ON THE SHC HIE AND PROVIDE THE FOLLOWING INFORMATION IN ORDER TO PARTICIPATE:

Physician's Name: Physician's Group Practice or Professional Association Name: **Practice/ P.A. OID Number: _____ (If physician or practice does not have an OID Number, leave blank, a generic number will be assigned.)**		
Address:	City:	State: Zip:
Email:	Phone Number: ( ) -	Fax Number: ( ) -

Administrative Use Only:

Received by:_____ Date:_____