The Ohio Health Information Partnership is a nonprofit organization that shares information about people's health electronically using the CliniSync Health Information Exchange.

What is the CliniSync Health Information Exchange?

The CliniSync Health Information exchange (HIE) is technology that allows healthcare information to pass electronically across organizations across the state. Clear and strict state and federal guidelines govern how the information can be exchanged, viewed and used. The goal of the HIE is to make the information available when and where it is needed.

How can sharing my information improve my care?

More Coordinated Care: Today, most doctors and hospitals use electronic health records rather than paper health records. Your doctor may search for and get your test results, lab results, x-rays, medication list or any other health information that has been electronically collected from other providers who are part of the CliniSync community network.

For example, information that could help save your life in a medical emergency would be available to the doctors in the emergency room (ER) if something happens that you did not expect. They would know what medications you are taking and what conditions you have. Another example would be that your cardiologist orders a special test and wants to share it with your primary care doctor. This could be done electronically, rather than on paper or through a dictated letter.

Less Unnecessary Testing: You may have had a lab test done recently at a hospital or doctor's office. When you go someplace else, they can use the exchange to see your prior lab test results. That may prevent the need to do the test again.

Is my information kept private?

Yes it is. The CliniSync Health Information Exchange follows U.S. and Ohio privacy laws. Only people providing care to you may view your medical records on the exchange. Anyone who is not involved in your care is not allowed to view your medical records on the exchange.

If you have questions, please contact CliniSync:

- Call **614-664-2600**
- **You also can visit our website at www.clinisync.org and search for Patient Choice**

Abco Medical Center

Request to Change Consent

I understand that my treating providers have access to my medical records through the CliniSync Health Information Exchange. These medical records include test results, lab results, X-rays, medication list and other health information that has been electronically collected from other participating providers from the HIE. This information could help save my life in a medical emergency if it is available to the health care professionals treating me. I understand that my choice will not affect my ability to get medical care or health insurance coverage.

If you DO NOT want to have your records shared, please mark the box below.

☐ **I do not want to have my records shared on the CliniSync Health Information Exchange. I understand that by submitting this Request for Non-Participation in CliniSync my test results and medical information will not be accessible to health care providers (including emergency room physicians) through CliniSync. I hereby authorize CliniSync to block access to my test results and medical health information through CliniSync. I understand that I may choose to participate in CliniSync again at any time by contacting any organization participating in CliniSync or by changing my selection on this form. I have read this form and have had a chance to ask questions.**

If you previously said you didn't want to have your records shared and now want them shared, please mark the box below. This will allow your status to be changed.

☐ **I consent to have my records shared through the Health Information Exchange. I have read this form. I have had a chance to ask questions. I am satisfied with the answers.**

First Name: _____ Middle Name: _____ Last Name :_____

Previous Last Name: _____ Date of Birth: _____ (ex.mm/dd/yyyy) Gender ☐Male ☐Female

Medical Record Number (MRN/Patient Identification Number) if known:_____

Street Address: _____

City _____ State: _____ Zip Code: _____

Phone: (_____) _____ Alternate Phone: (_____) _____

Email Address: _____ Last Four Digits of Social Security Number: _____

Patient Signature: X_____ **Date Signed:** _____

(If under the age of 18, signature of parent or legal guardian)

You can have the information below filled out by your medical provider's office staff, hospital or other facility so they can change your consent. OR, you can have it notarized and mail it to: Att: CONSENT STATUS, Ohio Health Information Partnership, 3455 Mill Run Drive, Suite 315, Hilliard, OH 43026.

Section to be completed by a Notary Public or Medical Office Staff:

I witnessed the above named individual sign this document and the individual is personally known to me or provided me with valid picture identification on this day ____ of _____, 20___.

Notary or Medical Office Staff Print Name: _____

Phone Number: _____

Notary or Medical Office Staff Signature: X_____