HARRISON HealthPartners

Consent to Access, Use and Share Protected Health Information For Electronic Prescribing and Health Information Exchange

Dear Patient:

By signing this consent you agree to allow your healthcare provider to electronically transmit your prescriptions to the pharmacy you designate.

You also consent to the disclosure or exchange of your prescription medication information to or from appropriate health providers, pharmacies, insurers or prescription benefits companies, specifically including any state or federal health program for the purpose of your treatment. Your consent includes the re-disclosure of protected health information maintained by a drug or alcohol treatment program.

_____ I Consent.

_____ I Decline Consent.

In addition, your healthcare provider is participating in Harrison Medical Center's Health Information Exchange (HIE). An HIE provides the technology necessary for your healthcare provider to share appropriate elements of your care with other healthcare providers to facilitate referral, diagnosis and treatment.

Please take a moment to read the consent below, and make your selection. Please ask one of our staff for more information if you have any questions.

_____ Opt to participate: The below named patient, or his/her representative, gives consent to licensed medical professionals to use and disclose his/her protected health information to facilitate referral, diagnosis and treatment for continuity of care.

_____ Opt **not** to participate: The below named patient, or his/her representative, refuses or revokes consent to licensed medical professional to use and disclose his/her protected health information to facilitate referral, diagnosis and treatment for continuity of care.

_____ _____

Print Patient Name Date of Birth

_____ _____

Patient Signature/Guardian Today's Date