PATIENT IDENTIFICATION (or affix patient label)

Patient Name:_____

Medical Record#: _____

Date of Birth: _____

Telephone#: Home_____Work_____

Provider Name: _____

Patient Consent for Health Information Exchange (HIE) of Protected Health Information (PHI)

First Name:	Middle Name:	Last Name:	Date of Birth: MM/DD/YYYY

Please read these statements <u>carefully</u>: *(If you are a patient's legal representative, "me", "my", or "I" refers to the patient)*.
By signing this form I understand that San Ysidro Health (SYHealth) is a member of multiple clinically integrated networks, primary care providers, and Health Center Partners Agencies who all work collaboratively to ensure access to quality and affordable healthcare to all. For more information about other networks, primary care providers, and health partner agencies please visit www.syhc.org.

I authorize my protected health information (PHI) to be utilized in providing me medical treatment. As well to support activities related to the coordination of care and other SYHealth Provided Services, clinically integrated networks, primary care providers, Health Center Partners, and other organizations such as 2-1-1 San Diego and its referral partners.

I understand and agree that SYHealth, the other health care providers, partners, and organizations may access, use, disclose and re-disclose all of my available health records and other information about me, from both before and after today's date. I understand that once my health information is disclosed to a person or entity that is not a provider or payor, my health information may be no longer be protected by federal confidentiality laws (45 CFR 164.508(c)(2)(iii). I understand and agree that the protected health information (PHI) that is disclosed may relate to the following highly sensitive conditions:

- Mental health or developmental disabilities
- Substance/alcohol abuse
- HIV test results
- Sexually transmitted diseases and other communicable diseases
- Family planning information

I understand the health information that is disclosed may include:

- Diagnostic information
- Demographics
- Medications and dosages
- Lab tests and results
- Allergies
- Care summaries and plans of care
- Housing situation and social supports
- Clinical notes
- Social history
- Orders
- Payers
- Employment information

I may revoke this consent in writing, at any time, by contacting SYHealth's HIS Department located at: 1601 Precision Park Lane, San Diego, CA 92173; provided, however, that such revocation will not apply to any sharing of my health information that occurred prior to the date the written revocation was received.

Effective Period: This Consent will remain in effect until the day I withdraw my consent, or within 10 years of no longer being an active patient here at SYHealth.

I have read and understood the contents of this consent form, and I am entitled to receive a copy upon request.

San Ysidro Health and its employees, contractors/vendors, and/or other Health Centers/ Partner Agencies will continue to treat me even if I choose to not sign this form.
(Please note: Eligibility for benefits, Enrollment, payment or treatment may not be conditioned on signing the authorization (45 CFR 164.508(c)(2)(ii))).

By providing your consent, you specifically authorize SYHealth to use and disclose information relating to Drug/Alcohol/Substance Abuse, Mental Health, and HIV. I understand that substance abuse records are protected under the federal regulations, 42 CFR Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164 and cannot be re-disclosed without my written consent unless otherwise permitted under the regulations.

☐ **OPT-IN**: I **authorize** to share my health information

☐ **OPT-OUT**: I **do not authorize** to share my health information

Patient Date of Birth:	Print Full Name of Legal Representative:
Print Patient Full Name:	If Signed by Legal Representative, Relationship to Patient:
Signature of Patient:	Signature of Legal Representative:
Date of Signature:	Date of Signature: