## **CHIE Patient Consent & Change Form**

THE CLINICAL HEALTH INFORMATION EXCHANGE (cHIE) IS HERE TO MAKE YOUR LIFE SIMPLER AND SAFER. With this form, you are choosing whether to allow your medical information to be accessed through a statewide secure electronic system called the cHIE.

FILL OUT THIS FORM COMPLETELY AND RETURN IT TO YOUR PARTICIPATING CHIE HEALTHCARE PROFESSIONAL. PATIENT INFORMATION (PLEASE PRINT):
CIDCT MANAC.
MIDDLE NAME:
LAST NAME:
DATE OF BIRTH: MM-DD-YYYY
DATE OF THE STATE
ADDRESS:
CITY: STATE: ZIP: GENDER:
MALE FEMALE
CONSENT OPTIONS PLEASE CHOOSE ONLY ONE BOX BELOW:
PARTICIPATE: I give consent to share and allow access to my medical records to participating healthcare professionals through the cHIE.
LIMITED: I give consent to share and allow access to my medical records to participating healthcare professionals through the cHIE for this non-emergency medical visit or for any emergency anytime. A new consent form must be completed for each non-emergency medical visit.
NOT-PARTICIPATE: I do not want my medical records accessed by any healthcare professional through the cHIE, even in an emergency.
You can change your consent at any time by going to a participating cHIE healthcare professional and requesting a change. Changes made to consent will be processed in a reasonable amount of time, and may not be immediate. Your current consent status will remain in effect until your request can be updated.
By signing this form, I acknowledge that I have read and understand my consent options as described herein. I also understand I can change my consent at any time by completing a new cHIE Patient Consent Form and returning it to a participating cHIE healthcare professional.
CICAIATURE OF DATIFATOR DATIFATICAL DEPOSITATION
SIGNATURE OF PATIENT OR PATIENT'S LEGAL REPRESENTATIVE DATE OF THIS CONSENT DECISION
PRINT NAME OF LEGAL REPRESENTATIVE (IF APPLICABLE)  RELATIONSHIP OF LEGAL REPRESENTATIVE
By signing as the patient's legal representative I certify that: the Patient's Name is accurate and correct, that I am the Parent or Legal Guardian of the Patient, and that I have authority to sign this Consent on the Patient's behalf.
REQUIRED - CONSENT WITNESSED BY AUTHORIZED AGENT To protect your privacy and verify your identity, your signature on this consent form must be witnessed by your healthcare professional or a cHIE representative.
Name of Organization: Name of Witness:
As a witness to this Consent, I attest that the above signer is personally known to me or has established his/her identity with me by satisfactory photo ID, insurance card, or other evidence of identity customarily relied upon in healthcare.