Mid-Ohio Pediatrics and Adolescents, Inc.

HEALTH INFORMATION EXCHANGE
PATIENT AUTHORIZATION FORM

Patient Information			
	Last Name	First Name	Middle
	Date of Birth		Other possible names
	Phone #	Address	
	City	State	Zip Code

A Health Information Exchange ("HIE") is a safe way for health care providers to get the most up-to-date health information about your child. The HIE will allow Mid-Ohio Pediatrics and Adolescents, Inc. and Nationwide Children's Hospital to access or share your child's health information with other healthcare providers. This may improve your child's overall care through the use of an electronic medical record. By signing this form, you are agreeing that your child's health information, including test results, lab reports, X-rays, medication lists or any other relevant electronic health information may be shared across participating health care providers.

You acknowledge that you read this form, were given the opportunity to ask questions and got answers you understood.

1. I understand that this authorization will expire one year from the date of my signature below.

2. I understand that I may revoke this authorization at any time by submitting a *Patient Withdraw Authorization Form* and submitting it to my healthcare provider, or by notifying, in writing, the Privacy Officer, at Nationwide Children's Hospital, 700 Children's Drive, Columbus, OH 43205. I understand that if I withdraw authorization, no new health information may be shared with the HIE and the health information already submitted to the HIE may not be used unless it has already been used in reliance on my previous authorization. This authorization will be shortened, extended or will cease to be effective on the date the written instructions are received except to the extent action has already been taken in reliance upon it.

3. I understand that if I previously exercised my right to opt-out of the HIE, and am now signing this form to be reinstated so that my health information can be electronically accessible through the HIE by authorized health care providers, that by signing this form all of my health information from both before and after today's date, including the period of time when I opted out, will be shared through the HIE.

4. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by state or federal privacy regulations. However, other state or federal laws may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.

5. I understand that my refusal to sign this authorization will not jeopardize my right to healthcare and payment for my healthcare except where disclosure of my health information is required for the provision of healthcare or to obtain payment for healthcare.

6. I understand that I can request a copy of this form after I sign it. A photocopy of this form will be considered as valid as the original.

______________________________ ______________________________

Print Name of Patient | Print Date of Birth

Signature of Patient or Legal Representative | Date | Time

Print Name of Legal Representative (if applicable) | Relationship of Legal Representative to Patient (if applicable)

Mid-Ohio Pediatrics and Adolescents, Inc.

HEALTH INFORMATION EXCHANGE
PATIENT WITHDRAW AUTHORIZATION FORM

Patient Information			
	Last Name	First Name	Middle
	Date of Birth		Other possible names
	Phone #	Address	
	City	State	Zip Code

I wish to WITHDRAW authorization for my child's participation in the Health Information Exchange. I understand that no new health information may be shared with the HIE and the health information already submitted to the HIE may not be used unless it has already been used in reliance on my previous authorization.

Print Name of Patient	Print Date of Birth
Signature of Patient or Legal Representative	Date Time
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)