Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

STANFORD HEALTH CARE
UNIVERSITY HEALTHCARE ALLIANCE
STANFORD HEALTH CARE - VALLEYCARE
STANFORD CHILDREN'S HEALTH
PACKARD CHILDREN'S HEALTH ALLIANCE

CONSENT PATIENT REQUEST FOR EXEMPTION

PATIENT REQUEST FOR EXEMPTION FROM PARTICIPATION IN ELECTRONIC HEALTH INFORMATION EXCHANGE

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Section A:

Patient name (last, first, middle): ______________________________

Address: ______________________________

SHC, UHA, SHC-VC, SCH, or PCHA
Medical Record Number (if known): ______________ Date of Birth: ______________

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Section B: SECURE ELECTRONIC HEALTH INFORMATION EXCHANGE

Secure electronic exchange of health information helps ensure better care and coordination of care. Stanford Health Care (SHC), the University Healthcare Alliance (UHA), Stanford Health Care-ValleyCare (SHC-VC), Stanford Children's Health (SCH), and Packard Children's Health Alliance (PCHA) participate in health information exchange(s) that allow outside providers who need information to treat you to request and receive your health information through secure electronic health information exchange. For example, your non-SHC, non-UHA, non-SHC-VC, non-SCH, or non-PCHA health care providers will be able to request and receive a summary of your allergies, medications, tests, and other clinical information which may not otherwise be readily available to them in your non-SHC, UHA, SHC-VC, SCH, or PCHA medical records.

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Section C: Request for Exemption from Participation in ELECTRONIC Health Information Exchange

I do not wish to participate in the release of my medical information from SHC, UHA, SHC-VC, SCH, or PCHA via secure health information exchange to my non-SHC, non-UHA, non-SHC-VC, non-SCH, or non-PCHA health care providers for my care management and treatment. I understand that by honoring this request, SHC, UHA, SHC-VC, SCH, and PCHA will not share my health information to my other providers via secure electronic health information exchange, except as otherwise authorized under State and Federal patient health information privacy laws.

I understand that my request to be exempted from the secure electronic health information exchange does not affect my non-SHC, non-UHA, non-SHC-VC, non-SCH, or non-PCHA health care provider's ability to otherwise obtain my SHC, UHA, SHC-VC, SCH, or PCHA health information through other approved release of information procedures.

I understand that by signing this request, my non-SHC, non-UHA, non-SHC-VC, non-SCH, and non-PCHA health care providers may not receive automatic notification via the secure electronic health information exchange system about my care provided by SHC, UHA, SHC-VC, SCH, or PCHA for continuity of care purposes.

I understand that my signed request becomes effective upon receipt and processing and will remain effective until and unless I request this to be changed. I understand that should I wish to rescind my request for exemption from secure electronic health information exchange to non-SHC, non-UHA, non-SHC-VC, non-SCH, or non-PCHA health care providers, I must submit my request in writing to Stanford Health Care, Health Information Management Services (HIMS) Department, 300 Pasteur Drive, MC 5200, Stanford, CA 94305 or fax it to (510) 974-2340.

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Section D: INFORMATION YOU SHOULD KNOW BEFORE SIGNING

If you have questions about this form or the release of your health information, please contact the SHC HIMS Department at (510) 974-2262 before signing.

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Section E:

By my signature dated below, I hereby request that Stanford Health Care (SHC), University Healthcare Alliance (UHA), Stanford Health Care-ValleyCare (SHC-VC), Stanford Children's Health (SCH), and Packard Children's Health Alliance (PCHA) do not release my health information via secure electronic health information exchange to non-SHC, non-UHA, non-SHC-VC, non-SCH, and non-PCHA health care providers as described in Section C above.

Name of patient (please print):

____

Name of legal representative signing this form, if applicable (please print):

____

Address of patient or legal representative signing this form (please print):

____

Phone number of patient or legal representative signing this form (please print):

____

If you are not the patient and you are signing this form, describe your authority to sign on behalf of the patient and provide supporting legal documentation:

____

Personal Representative's Name (print) and Relationship

Signature of patient or legal representative: ____________________________ *Date:* ______________

*** A COPY OF THIS FORM MUST BE GIVEN TO THE PATIENT ***