DOCTORS CAN NOW SHARE MY MEDICAL RECORDS ELECTRONICALLY!

Automatic Consent

You're automatically enrolled in the Health Information Exchange so your medical records can be electronically shared among your doctors. You can opt out of the exchange by filling out the back of this form and giving it to practice staff.

Important Information for Doctors

Sharing records electronically is a simple, fast way for your healthcare provider to get a "whole" picture of your health in one record, no matter where you have been treated in Ohio.

Saving Time & Lives

This is especially important in an emergency, when you may be unconscious or unable to speak. Your doctor can save time and even your life when your medical history is right there.

Improved Patient Safety

If you're away from home and in Ohio when you get sick, clinicians can view what medical problems you have and see any allergies you might have. This improves your care and your

Quicker Results

When your doctor orders tests, the health information exchange quickly sends those results in real time. Your physician also can get the most up-to-date and accurate information from others who have treated you.

Increased Privacy & Security

Only doctors and staff who treat you can look at your health information. Your records remain private in a secure network that is audited.

If you wish to opt out of the Health Information Exchange, please fill out the form on the back of this page. Thank you!

REQUEST TO CHANGE CONSENT

I understand that my treating providers have access to my medical records through the CliniSync Health Information Exchange.

If you DO NOT want to have your records shared, please mark the box below.

☐ I don't want to have my records shared on a Health Information Exchange. I understand that my test results and medical information will not be accessible to healthcare providers (including emergency room physicians) through CliniSync. I understand that I may choose to participate in CliniSync again at any time.

If you previously said you didn't want to have your records shared and NOW WANT them shared, please mark the box below. This will allow your status to be changed.

☐ I consent to have my records shared through the Health Information Exchange. I have read this form. I have had a chance to ask questions. I am satisfied with the answers.

First Name: ______________________________ Middle Name: ______________

Last Name: ______________________________

Previous Last Name: ______________________ Date of Birth: ________________

Gender: Male ☐ Female ☐

Street Address: ____

City: __________________________ State: _________ Zip Code: ___________

Phone: (_____)______________OR Cell: (_____)______________________

Email Address: ____

Social Security Number: ____________________________

Patient Signature: X _________________________________ Date: _____________

(If under the age of 18, signature of parent or legal guardian)______________________

You can have the information below filled out by your medical provider's office staff, hospital or other facility so they can change your consent. OR, you can have it notarized and mail it to:

Att: Privacy Officer, 1111 Hayes Ave., Sandusky, Ohio 44870

Section to be completed by a Notary Public or Medical Office:

I witnessed the above named individual sign this document and the individual is personally known to me or provided me with valid picture identification on this day ____ of ______________, 20______.

Notary or Medical Office Staff Print Name: ____________________________________

Phone Number: ______________________________