

# Patient Consent Form for Electronic Exchange of Individual Health Information



HealthHIE Nevada is a non-profit organization dedicated to connecting the healthcare community to share information electronically and securely to improve the quality of healthcare services. To learn more about the Health Information Exchange (HIE), read the Patient Information brochure. You can ask the doctor that gave you this form for it, or go to the website [www.healthHIenevada.org](http://www.healthHIenevada.org).

## Details about patient information in HealthHIE Nevada and the consent process:

- 1. How your information will be used and who can access it:** When you provide consent, only HealthHIE Nevada participants (such as doctors, hospitals, laboratories, radiology centers, and pharmacies), will have access to your health information. It can only be used to:
  - Provide you with medical treatment and related services.
  - Evaluate and improve the quality of medical care provided to all patients, using de-identified health information.
- 2. Types of information included and where it comes from:** The information about you comes from organizations that have provided you with medical care, and are HealthHIE Nevada participants. These may include hospitals, physicians, pharmacies, clinical laboratories, and other healthcare organizations. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medications your doctor has prescribed. This may include information created before the date of this Consent Form. This information may relate to sensitive health conditions, including but not limited to:
  - Alcohol or drug use problems
  - HIV/AIDS
  - Birth control and abortion (family planning)
  - Genetic (inherited) diseases or tests
  - Mental health conditions
  - Sexually transmitted diseases
- 3. Improper Access or Disclosure of your Information:** Electronic information about you may be disclosed by a participating doctor to others only to the extent permitted by Nevada State Law. If at any time you suspect that someone who should not have seen or received information about you has done so, you should notify your doctor.
- 4. Effective Period:** Your consent becomes effective upon signing this form and will remain in effect until the day you revoke it or HealthHIE Nevada ceases to conduct business.
- 5. Revoking your consent:** At any time, you may revoke your consent by signing a new consent form and giving it to your doctor. These forms are available at your doctor's office, or by calling 855-484-3443. Changes to your consent status may take 24-48 hours to become active in the system.

Note: Organizations that access your health information through HealthHIE Nevada while your consent is in effect may copy or include your information into their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

- 6. How your information is protected:** Federal and State laws and regulations protect your medical information. HIPAA, the Healthcare Insurance Portability and Accountability Act of 1996, is the federal law that protects your medical records and limits who can look at and receive your health information, including electronic health information. HIPAA's protections were further strengthened by another federal law, the HITECH Act of 2009, which may impose severe financial fines on anyone who violates your medical privacy rights. All health information made available on the HIE, including your medical information, is encrypted to federal standards and is accessible only as allowed by Nevada State law (NRS 439.590). In addition, your doctor must provide you with a Notice of Privacy Practices, which describes how he or she uses and protects your medical information.

Copy of Form: You are entitled to receive a copy of this Consent Form after you sign it.



For Internal Use Only: MRN \_\_\_\_\_

## Patient Consent Form for Electronic Exchange of Individual Health Information

Please read through the consent form and provide the following information: (Please Print)

PATIENT NAME \_\_\_\_\_  
Last First Middle

PREVIOUS NAME(S) \_\_\_\_\_ GENDER: M \_\_\_ F \_\_\_

STREET ADDRESS /  
P.O. BOX \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

PHONE NUMBER \_\_\_\_\_ EMAIL \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ (MM) \_\_\_\_\_ (DD) \_\_\_\_\_ (YYYY)

**Nevada Medicaid Patients Please Read:** Nevada law mandates that “a person who is a recipient of Medicaid or insurance pursuant to the Children’s Health Insurance Program may not opt out of having his or her individually identifiable health information disclosed electronically” (NRS 439.539). When a patient is no longer a Medicaid recipient, it is the patient’s responsibility to change their consent choice, if they choose to do so. Please sign below to indicate your acknowledgement.

**Consent Choices: (CHECK ONE) Nevada Medicaid Patients are exempt from making a selection.**  
Your choice to give or to deny consent may not be the basis for denial of health services.

**I CONSENT** for all HIE participants to access **ALL** of my electronic health information (including sensitive information) in connection with providing me any health care services, including emergency care.

**I CONSENT ONLY IN CASE OF AN EMERGENCY** for all HIE participants to access **ALL** of my electronic health information (including sensitive information) **ONLY** in the event of a medical emergency.

**I DO NOT CONSENT** for any HIE participants to access **ANY** of my electronic health information **EVEN** in the event of a medical emergency.

\_\_\_\_\_  
**Signature of patient or authorized representative**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

If I sign this form as the Patient’s Authorized Representative, I understand that all references in this form to “I”, “me” or “my” refer to the Patient.

\_\_\_\_\_  
Name of Authorized Representative (Printed)

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Address of authorized representative signing this form (please print):

\_\_\_\_\_  
Phone number of authorized representative

### FOR INTERNAL USE ONLY

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 health care.