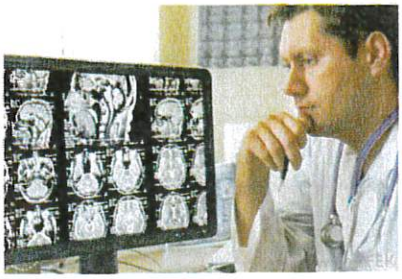


MY DOCTORS CAN NOW SHARE MY MEDICAL RECORDS ELECTRONICALLY!

Automatic Consent

You are automatically enrolled in the Health Information Exchange so your medical records can be electronically shared among your doctors. You can opt out of this exchange by filling out the front page of this document.

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 and 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 safety.

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.

Privacy and 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.

GENERATIONS
WOMEN'S HEALTH

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 ☐ Undisclosed

Street Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: (____) _____-_____ Secondary Phone: (____) _____-_____

Email Address: _____

Last Four Digits of Social Security Number: _____

Patient Signature: _____ 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: ***Attn: CONSENT STATUS, Ohio Health Information Partnership, 3455 Mill Run Drive, Ste 315, Hilliard, OH 43026.***

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

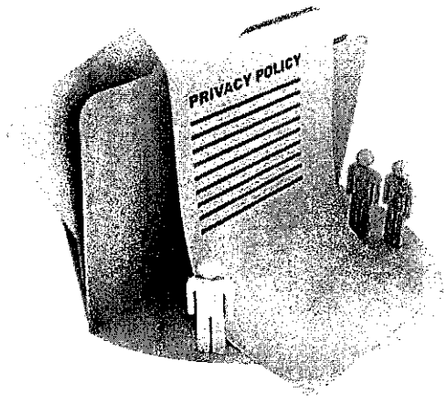
I witnessed the above named individual sign this document and the individual is personally know to me or provided me with valid picture identification on this day _____ of _____, 20_____.

Notary or Medical Office Staff Print Name: _____

Phone Number: (____) _____-_____

Notary or Medical Office Staff Signature: _____

Notice of Privacy Practices (NPP)/Consent



We participate in one or more Health Information Exchanges. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. We and other healthcare providers, may allow access to your health information through the Health Information Exchange for treatment, payment or other healthcare operations. This is a voluntary agreement. *You may opt-out at any time by notifying [the Health Information Management Services/Medical Records Department] OR [the office administrator].*