COMMUNITY HIE PATIENT DISCLOSURE AUTHORIZATION Patient Information

Patient Name: Phone Number:

Date of Birth: Address:

Brookside Family Medicine participates in a Community Health Information Exchange (Community HIE) operated by Northern Physicians Organization, Inc. (NPO). The Community HIE is also connected to the Michigan Health Information Network (MiHIN), which is the statewide health information exchange. This Community HIE and MiHIN are tools that we and others involved in your care can use to carry out your treatment and engage in health care operations activities to help manage your care such as coordinating your care, conducting quality assessment and improvement activities, patient safety activities and related planning and management activities that do not include treatment. The Community HIE also allows us to see a longitudinal view of your care.

__ I opt-out of the NPO Community HIE.

- OR -

X_ I understand that by signing this form, I agree to participate in the NPO Community HIE and agree to allow the providers involved in my health care to talk to each other about my care, electronically share my health information with each other to give me better care, and to use my information in health care operations.

WHAT MAY BE DISCLOSED: I authorize my Provider to disclose all of my health information, including demographic information, allergies, medications, immunizations, lab reports, problems and diagnosis, mental health conditions, birth control and abortion, alcohol or drug use problems, my care plan, health care providers, sexually transmitted diseases (STDs), HIV/AIDS, and genetic diseases or test results. This includes information created before and after the date of this Authorization.

WHO MAY RECEIVE THE INFORMATION:

(1) I authorize my Provider to disclose my health information to NPO, its participating physicians, physician groups, care plan manages, labs, pharmacies, and others involved in my care that have entered into a written agreement with NPO, before or after the date of this Authorization; and

(2) I authorize NPO to disclose my health information to

(a) NPO's participating physicians and physician groups that have entered into a written agreement with NPO, before or after the date of this Authorization;

(b) other health care service providers (*e.g.*, labs and hospitals) that have entered into a written agreement with NPO, before or after the date of this Authorization, where they have agreed to comply with HIPAA and Michigan privacy laws; and

(c) MiHIN and its network of physicians, physician groups, and other health care service providers, who have agreed to comply with HIPAA and Michigan privacy laws.

PURPOSES: I allow disclosure of my health care information for medical treatment, to coordinate care among my providers, for patient safety and population health management activities, and to improve my provider's health care operations.

EXPIRATION: If not previously revoked, this Authorization will expire on the *earliest of* the following: **(i)** upon my death, **(ii)** when my Provider ceases its relationship with NPO, **(iii)** NPO ceases operation of the Community HIE, or **(iv)** if I am under eighteen, when I turn eighteen.

REVOCATION: I can revoke this Authorization at any time by giving written notice to my Provider. I understand that my revocation does not apply to any information already released as a result of this Authorization.

ADDITIONAL RIGHTS: I understand that I have additional rights under HIPAA, including the right to request restrictions on certain uses and disclosures of my health information, the right to inspect and copy my health information, and the right to request amendments to my health information, and that these rights are further explained in my Provider's Notice of Privacy Practices. I am entitled to a copy of this Authorization. I also understand that I may refuse to sign this Authorization, and that the Provider cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

POTENTIAL FOR RE-DISCLOSURE: I understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient, in which case it may no longer be protected under the HIPAA Privacy Rule.

Signature of Patient: ___________________________ Date :_________________

____ ______________________

Signature of Parent/Guardian or Personal Representative Relationship to Patient