GUTHRIE

Patient Name:_____ Maiden/Previous Name: _____Gender:_____
Date of Birth:_____Last 4 digits of Social Security #(Optional):_____ MedicalRecord #: _____
Address: _____
(Street) *(City)* *(State)* *(Zip)*

The Guthrie Clinic understands that you may have health care providers caring for you that are both inside and outside of The Guthrie Clinic organization. A Health Information Exchange (HIE) is one mechanism that allows for the electronic sharing of health-related information among organizations that provide your care. The Guthrie Clinic Electronic Health Record computer system allows for electronic "sharing" of your health information to help provide access to your health information wherever you are. This could be especially important in emergency care situations.

CONSENT: I understand that by giving consent as indicated below, I am allowing The Guthrie Clinic to release and/or allow access to ALL of my electronically available health information to other health care providers in connection with providing me health care services including emergency care. Electronically available health information may include information from my health care providers, including, Guthrie Medical Group, Troy Comuunity Hospital, Corning Hospital, Robert Packer Hospital , and other hospitals that join The Guthrie Clinic, physicians, clinics, pharmacies, labs, and other licensed providers, as well as a third party organization that assists in the exchange of my information. Information may also be shared for public health activites and immunization registries.

TYPES OF INFORMATION INCLUDED IN THIS CONSENT: I understand that this authorization permits The Guthrie Clinic to allow access and/or disclose ALL of my electronically available health information, including but not limited to, information related to drug/alcohol abuse, HIV/AIDS testing, status or treatment; genetic diseases or genetic tests; family planning/reproductive care; sexually transmitted diseases; mental health, emergency care records, nursing notes, immunization histories,laboratory results, pathology reports, x-ray reports, films, and all other health information as allowable under applicable law.

YOUR SIGNATURE: I understand that my consent becomes effective upon signing this form and will remain in effect until I submit a written request to revoke it. This consent permits access to and disclosure of my health information created both before and after the date I sign this form. I understand that I have the right to withdraw or revoke this consent in writing at any time, except to the extent that the electronic health information has already been released to another entity. To revoke this consent or request additional information regarding privacy concerns please call ***1-888-841-4644*** or address request to:

The Guthrie Clinic
Attention: Privacy Officer
1 Guthrie Square, Sayre PA 18840

I GIVE AUTHORIZATION FOR The Guthrie Clinic to release and/or permit access to ALL of my electronic health information through Electronic Exchanges or via direct access.

Signature of patient or authorized representative:

By signing 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.

_____ Date: _____

If signed by someone other than the patient, print name and indicate relationship:

_____ _____ _____
Authorized Representative *Relationship* *Date*

_____ _____
Address of Authorized Representative signing this form (please print): *Phone*

Signature of witness: _____ *Date:* _____

I <u>DECLINE AUTHORIZATION</u> FOR The GuthrieClinic to release and/or permit access to my electronic health information through Electronic Exchanges.

Signature of patient or authorized representative:

_____ Date: _____