Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

STANFORD HEALTH CARE
STANFORD MEDICINE PARTNERS
STANFORD HEALTH CARE TRI-VALLEY
STANFORD CHILDREN'S HEALTH
PACKARD CHILDREN'S HEALTH ALLIANCE

CONSENT PATIENT REQUEST FOR EXEMPTION

PATIENT REQUEST FOR EXEMPTION FROM PARTICIPATION IN ELECTRONIC HEALTH INFORMATION EXCHANGE

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Section A:

Patient name (last, first, middle): _____

Address: _____

Stanford Health Care, Stanford Medicine Partners, Stanford Health Care Tri-Valley, Stanford Children's Health, or Packard Children's Health Alliance
Medical Record Number (if known): _____ Date of Birth: _____

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Section B: SECURE ELECTRONIC HEALTH INFORMATION EXCHANGE

Secure electronic exchange of health information helps ensure better care and coordination of care. Stanford Health Care, Stanford Medicine Partners, Stanford Health Care Tri-Valley, Stanford Children's Health, and Packard Children's Health Alliance participate in health information exchange(s) that allow outside providers who need information to treat you to request and receive your health information through secure electronic health information exchange. For example, your non-Stanford Health Care, non-Stanford Medicine Partners, non-Stanford Health Care Tri-Valley, non-Stanford Children's Health, or non-Packard Children's Health Alliance health care providers will be able to request and receive a summary of your allergies, medications, tests, and other clinical information which may not otherwise be readily available to them in your non-Stanford Health Care, Stanford Medicine Partners, Stanford Health Care Tri-Valley, Stanford Children's Health, or Packard Children's Health Alliance medical records.

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Section C: Request for Exemption from Participation in ELECTRONIC Health Information Exchange

I do not wish to participate in the release of my medical information from Stanford Health Care, Stanford Medicine Partners, Stanford Health Care Tri-Valley, Stanford Children's Health, or Packard Children's Health Alliance via secure health information exchange to my non-Stanford Health Care, non-Stanford Medicine Partners, non-Stanford Health Care Tri-Valley, non-Stanford Children's Health, or non-Packard Children's Health Alliance health care providers for my care management and treatment. I understand that by honoring this request, Stanford Health Care, Stanford Medicine Partners, Stanford Health Care Tri-Valley, Stanford Children's Health, and Packard Children's Health Alliance will not share my health information to my other providers via secure electronic health information exchange, except as otherwise authorized under State and Federal patient health information privacy laws.

I understand that my request to be exempted from the secure electronic health information exchange does not affect my non-Stanford Health Care, non-Stanford Medicine Partners, non-Stanford Health Care Tri-Valley, non-Stanford Children's Health, or non-Packard Children's Health Alliance health care provider's ability to otherwise obtain my Stanford Health Care, Stanford Medicine Partners, Stanford Health Care Tri-Valley, Stanford Children's Health, or Packard Children's Health Alliance health information through other approved release of information procedures.

I understand that by signing this request, my non-Stanford Health Care, non-Stanford Medicine Partners, non-Stanford Health Care Tri-Valley, non-Stanford Children's Health, and non-Packard Children's Health Alliance health care providers may not receive automatic notification via the secure electronic health information exchange system about my care provided by Stanford Health Care, Stanford Medicine Partners, Stanford Health Care Tri-Valley, Stanford Children's Health, or Packard Children's Health Alliance for continuity of care purposes.

I understand that my signed request becomes effective upon receipt and processing and will remain effective until and unless I request this to be changed. I understand that should I wish to rescind my request for exemption from secure electronic health information exchange to non-Stanford Health Care, non-Stanford Medicine Partners, non-Stanford Health Care Tri-Valley, non-Stanford Children's Health, or non-Packard Children's Health Alliance, I must submit my request in writing to Stanford Health Care, Health Information Management Services (HIMS) Department, 300 Pasteur Drive, MC 5200, Stanford, CA 94305 or fax it to (510) 974-2340.

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Section D: INFORMATION YOU SHOULD KNOW BEFORE SIGNING

If you have questions about this form or the release of your health information, please contact the Stanford Health Care HIMS Department at (510) 974-2262 before signing.

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Section E:

By my signature dated below, I hereby request that Stanford Health Care, Stanford Medicine Partners, Stanford Health Care Tri-Valley, Stanford Children's Health, and Packard Children's Health Alliance do not release my health information via secure electronic health information exchange to non-Stanford Health Care, non-Stanford Medicine Partners, non-Stanford Health Care Tri-Valley, non-Stanford Children's Health, and non-Packard Children's Health Alliance health care providers as described in Section C above.

Name of patient (please print):

_____

Name of legal representative signing this form, if applicable (please print):

_____

Address of patient or legal representative signing this form (please print):

_____

Phone number of patient or legal representative signing this form (please print):

_____

If you are not the patient and you are signing this form, describe your authority to sign on behalf of the patient and provide supporting legal documentation:

_____

Personal Representative's Name (print) and Relationship

Signature of patient or legal representative: _____ *Date:* _____

*** A COPY OF THIS FORM MUST BE GIVEN TO THE PATIENT ***