Velatura HIE Co Authorization and Consent Form *September 2020*

Who is this form for?

It is for patients who want to join the Velatura HIE Co (VHIEC) Health Information Network.

What are you agreeing to by signing this form?

- To give consent that allows your health care providers to share your health records electronically, through their computers, to better care foryou.
- That you have received information about sharing your health records through the VHIEC Network.

Please read the statements below.
(If you are a patient's legal representative, "me," "my" or "I" refer to the Patient)

By signing this form, I understand and agree that VHIEC and health care providers participating in the VHIEC Network:

1. Will share my health data with providers who are treating me.
2. Will be able to see all of my health records from both before and after today's date.
3. May use or share my health data, but only as allowed by federal and state laws. This is the same as for my health records in paper form.
4. May share *all* of my health records with providers who are treating me; this includes but is not limited to:
   - illnesses or injuries (like diabetes or a broken bone)
   - test results (like X-rays or blood tests)
   - medicines I am taking or have taken

   This may also include, but is not limited to sensitive data:

   - Alcohol or substance abuse problems
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Mental health and developmental disabilities
   - Family planning information (including abortions)
   - Sexually transmitted diseases
   - Head and spinal cord injuries
5. May copy or include my health data in their own medical records when caring for me. Even if I later cancel my consent, providers I have visited who have copied my records are not required to remove them. This is the current law.
6. Have penalties in place for anyone sharing my data in the wrong way.
7. VHIEC will keep track of who views my health records to make sure they are secure. I can ask my doctor or VHIEC for a list of who has looked at my records. List of Current Providers: www.velatura.org/velatura-hie.

What is Velatura HIE Co (VHIEC)?

VHIEC is the nonprofit, Health Information Network for the Midwest. This secure, electronic network allows your doctors and other caregivers to share your health records quickly to provide you with the best care.

Who has access to the VHIEC Network?

Only authorized health care providers/organizations and professionals involved in your treatment, coordination of care, quality improvement and activities related to management or payment of your health care. Medical record information is protected under federal and state privacy laws; access, use and disclosure of medical records will comply with the laws.

Please read and understand each of the following statements:

- Using this data for marketing or advertising purposes, or to determine insurance or employment eligibility, is strictly prohibited.
- My consent will remain in effect for a period of one year from the date of processing. After the one-year time frame, my consent decision will expire.
- My consent to join VHIEC is voluntary. I can cancel my consent at any time. I can rejoin at any time.
- It may take 2-5 business days after receipt, to process this Opt-In from and to allow the sharing of my health information through the VHIEC HIE.
- If I suspect or learn that my data was shared or accessed in the wrong way, I may contact VHIEC at: www.velatura.org/velatura-hie or PMB 270, 2000 E. Broadway, Columbia, MO 65201-6091.

Patient Information:

By signing this form, I give all VHIEC participating providers the right to share all of my health records, including sensitive data, through VHIEC Network for purposes of providing care to me. VHIEC has the right to contact me do identityverification.

____ ____/____/_______

My Name (Please Print and include maiden name, if applicable) Date of Birth

____

My Address City

____ ____/____/_______

State Zip Code Gender Social Security

Patient Signature:

X____

If I am the parent or guardian of a child, I can consent on behalf of the child only until he/she turns 18. At that time, the consent decision will expire.

This area is to be completed by a Notary Public

The foregoing instrument was acknowledged before me, a Notary Public, on_________/_____/______(date) by

____(patient name), known to me to be the person whose name is subscribed to the within instrument & acknowledged that he/she executed the same for the purposes therein contained.

Notary Signature:______________________________State:________County: ___________________

Submission Instructions: **Notary Stamp:**

Mail To: Velatura HIE Co
PMB 270
2000 East Broadway
Columbia MO 65201