

NC HISPC Consent for Use and Release of Information

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CONSENT FOR USE AND RELEASE OF INFORMATION

- A. I hereby consent to have information contained in my medical records, including information about my health and treatment and other personally identifying information about me ("Data"), entered into the electronic medical record of _____ ("Provider") and thereafter made available for access, review, and use by and disclosure to certain third parties noted below ("Authorized Users") through an electronic patient data exchange system ("Exchange"). My Data may be made available to Authorized Users through the Exchange as needed in order to provide me with health care items or services, in order to process payment for such items or services, or in order for Provider or other Authorized Users of the Exchange to perform functions necessary to their business operations.
- B. Specifically, I authorize Provider and any licensed physicians and other health care practitioners involved in providing services to me at Provider to use and release my Data (except psychotherapy notes) obtained during this visit/registration for purposes of treatment, payment, and health care operations as stated in Provider's Notice of Privacy Practices. For example, I authorize Provider, the independent practitioner(s) and any others involved in providing services to me at Provider to release my medical records and any information, confidential or otherwise, to each other and to all third party payors including, but not limited to, insurance companies, Medicare or Medicaid, or other responsible payors, as well as any company, intermediary, or person involved in reviewing, authorizing or processing claims for any of these entities that is necessary to bill and seek payment for the services, equipment and/or supplies provided to me.
- C. [If record locator service is used.] I understand that the Exchange includes a Record Locator Service index ("RLS") containing my name, address, and other non-clinical information used to identify me, along with the names of health care providers in the Exchange who have provided treatment to me. Only information Provider has about me from treatment provided today or later will be linked to the RLS.

___ (initial) I consent to Provider releasing this non-clinical information to the RLS

OR

___ (initial) I do not consent to Provider releasing this non-clinical information to the RLS

- D. I understand that my Data could include medical history or information regarding first time diagnosis or treatment of me for a communicable disease (such as sexually transmitted diseases, HIV/AIDS, tuberculosis or hepatitis), mental illness, or alcohol or substance abuse. **Unless I initial otherwise below, this information may be released to the following specific Authorized Users:**
- 1) Third party insurance companies, managed care companies, Medicare, Medicaid, workers' compensation or other payors that I identify as possibly responsible for payment of the services that have been provided;
 - 2) Independent physicians or health care practitioners involved in my care;
 - 3) Persons or agencies involved in processing applications for or determining my eligibility for financial benefits;
 - 4) Any person or external review agency involved in reviewing, authorizing, or processing my eligibility for health insurance coverage, payment of benefits, or billing compliance for such potential payors that I identify;
 - 5) National or regional registries or quality improvement organizations;
 - 6) Emergency transport services that transport me to or from the Hospital;
 - 7) Persons, physician practices, facilities, or agencies to which I am referred that represent to the Hospital that I have been referred to them for treatment, that assist with identifying, or that are contacted concerning possible appropriate care for me during my stay or after;
 - 8) Family or persons that I or my representative involve in my care;
 - 9) Agencies of the North Carolina Department of Health and Human Services (DHHS). I understand that I may object in writing to the on-site inspection of my health system records by the N.C. DHHS and thereby prohibit such inspection;
 - 10) County health care providers that are involved in my care or benefits, such as county Mental Health, Public Health and Social Services Departments.

I do not consent to release of the following information to the Exchange:

___ (initial) I do not consent to the release of information about me relating to communicable disease or treatment for it, including HIV, AIDS, or AIDS-related conditions

___ (initial) I do not consent to the release of information about me relating to psychological or psychiatric conditions or treatment for them

___ (initial) I do not consent to the release of information about me relating to alcohol or substance abuse or treatment for them

___ (initial) I do not consent to the release of information about me relating to genetic testing

- E. I understand that my Data may not be protected from re-disclosure by the requester of the information through the Exchange; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that this consent will not expire. However, I understand that I may revoke or discontinue my consent at any time by notifying Provider in writing, except to the extent that actions already have been taken based upon my consent, including the disclosure of my Data to third party payors to seek payment for the care and treatment provided to me. My revocation shall take effect one business day after my request has been received by Provider's Privacy Officer. I understand that I may request restrictions on disclosure of any of the above Data by completing Provider's Request for Restriction of Health Information form. I understand and agree to the above releases, authorizations, and assignments of benefits.

If I sign as a representative of the patient, I understand that I am certifying to Provider that I have legal authority to act for the patient or the patient has given me authority to act on his or her behalf.

Patient, Parent, Guardian, or Authorized Representative Date

Relationship to and authority to act for Patient

Witness Date

Acknowledgment of Receipt of the _____ Notice of Privacy Practices

I certify that I have received a copy of the _____ Notice of Privacy Practices and that I have authority to sign, as the patient or as a representative of the patient, to consent to use, disclosure and release of information as discussed in the Notice of Privacy Practices.

Signature: _____ Date: _____ □

Signature obtained after initial registration