SHIELD MEDICAL GROUP
QUICK, COMPREHENSIVE AND COST EFFECTIVE CARE

CONSENT FOR ELECTRONIC SHARING OF HEALTH INFORMATION

By signing this form, I authorize Shield Medical Group to exchange all of my protected healthcare information ("PHI") electronically through health information exchange systems ("HIE") including, but not limited to, regional and state health information exchanges, software platforms and other systems used to exchange PHI electronically. This includes all PHI contained in my electronic medical record, including medical history, diagnosis, treatment, examination, laboratory tests, and medications. I specifically authorize the exchange of my Sensitive Information through HIE as allowed on this form. Sensitive Information includes particularly confidential conditions such as mental health, psychological or psychiatric conditions; genetic information and related tests; drug, alcohol and/or substance abuse; HIV/AIDS, including tests for such conditions; sickle cell anemia; hospice care; birth control and family planning; and sexually transmissible diseases. PHI may be shared electronically through HIE with outside providers and entities, both inside and outside the United States, who request my information and indicate that they are involved in my care or treatment or are otherwise permitted by law to access my PHI. Even if I do not provide my consent below, Shield Medical Group may release my PHI electronically to treat an emergency medical condition when the health care provider is unable to obtain consent or the situation requires immediate medical attention.

I understand that I may request that my PHI no longer be shared through HIE by following the procedures outlined in the Notice of Privacy Practices for requesting restrictions. This authorization may be used to share all PHI maintained by Shield Medical Group, even if obtained before or after the date of this authorization. If Shield Medical Group grants my request for restriction, my revocation will be effective upon receipt by Shield Medical Group, but will not apply to any PHI already released as a result of this authorization and consent. I further understand that my PHI may contain information related to health plans, insurance benefits, worker's compensation programs, immunizations, educational programs, state programs and registries, and employers. I understand that my PHI shared per this authorization may be re-disclosed by the person or entity that receives it and, once shared, such PHI may no longer be protected by state or federal privacy laws if the recipient is not subject to those laws.

Shield Medical Group will provide me with a copy of this form upon request. I understand that I do not have to sign this form. If I do not sign, providers inside and outside Shield Medical Group may not be able to obtain my information through HIE, but it will not prevent Shield Medical Group from treating me. This consent expires ten (10) years after I am no longer a patient of Shield Medical Group.

Patient/Patient Representative Name	Date Signed
Signature	Relationship to Patient (if not signed by patient) ❑ Parent ❑ Legal Guardian ❑ Other (explain authority):

STAFF USE ONLY

❑ Accepted ❑ Declined

Received by: _____ Date: _____
Name and Title