

## Request to Change Consent

I understand that my treating providers have access to my medical records through the CliniSync Health Information Exchange.

If you **DO NOT** want to have your records shared, please mark the box below.

**I don't want to have my records shared on a Health Information Exchange.** I understand that my test results and medical information will not be accessible to healthcare providers (including emergency room physicians) through CliniSync. I understand that I may choose to participate in CliniSync again at any time.

If you previously said you didn't want to have your records shared and **NOW WANT** them shared, please mark the box below. This will allow your status to be changed.

**I consent to have my records shared through the Health Information Exchange. I have read this form. I have had a chance to ask questions. I am satisfied with the answers.**

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Previous Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Gender:  Male  Female  Undisclosed

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Secondary Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email Address: \_\_\_\_\_

Last Four Digits of Social Security Number: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

(If under the age of 18, signature of parent or legal guardian): \_\_\_\_\_

You can have the information below filled out by your medical provider's office staff, hospital or other facility so they can change your consent. **OR**, you can have it notarized and mail it to: **Attn: CONSENT STATUS, Ohio Health Information Partnership, 3455 Mill Run Drive, Ste 315, Hilliard, OH 43026.**

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### Section to be completed by a Notary Public or Medical Office:

I witnessed the above named individual sign this document and the individual is personally know to me or provided me with valid picture identification on this day \_\_\_\_\_ of \_\_\_\_\_, 20\_\_\_\_.

Notary or Medical Office Staff Print Name: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Notary or Medical Office Staff Signature: \_\_\_\_\_



**MY DOCTORS CAN  
NOW SHARE MY  
MEDICAL RECORDS  
ELECTRONICALLY!**



### **Automatic Consent**

*You are automatically enrolled in the Health Information Exchange so your medical records can be electronically shared among your doctors. You can opt out of this exchange by filling out the front page of this document.*

### **Important Information for Doctors**

*Sharing records electronically is a simple, fast way for your healthcare provider to get a “whole” picture of your health in one record, no matter where you have been treated in Ohio.*

### **Saving Time and Lives**

*This is especially important in an emergency, when you may be unconscious or unable to speak. Your doctor can save time and even your life when your medical history is right there.*

### **Improved Patient Safety**

*If you’re away from home and in Ohio when you get sick, clinicians can view what medical problems you have and see any allergies you might have. This improves your care and your safety.*

### **Quicker Results**

*When your doctor orders tests, the health information exchange quickly sends those results in real time. Your physician also can get the most up-to-date and accurate information from others who have treated you.*

### **Privacy and Security**

*Only doctors and staff who treat you can look at your health information. Your records remain private in a secure network that is audited.*