www.williamdennismd.com **Electronic Health Exchange Collaborative**

Permission to create an eEHX Summary and share My Medical Information

We are taking part in an exciting program to improve your health care and make office visits easier and more convenient. To do this, Dr Dennis would like your permission to enroll you in our eEHX Summary program. This means sharing important parts of your medical information with other providers (doctors, nurses and health professionals) through an electronic medical chart. Only authorized healthcare professionals, their agents and others whose job it is to secure, monitor and evaluate the operation of the information system and quality of care would be able to access your information. The eEHX Summary will allow your providers to access your health information more quickly and accurately than with paper charts.

The eEHX Summary is an overview of vital medical information. For instance, the eEHX Summary may include a list of your current medications, allergies, recent diagnoses (problems) and any surgery you may have had. It will not include detailed confidential notes from your office visits. Information in the eEHX Summary may include, but is not limited to, that which South Carolina law considers "sensitive" such as mental health, substance abuse, sexually transmitted disease, and sexual abuse information. HIV/AIDS diagnoses and any genetic testing results for health screening purposes will not be included in the eEHX Summary without your written permission each time it is used.

The eEHX Summary has a security system to protect your healthcare information. All authorized healthcare professionals with access to the eEHX Summary agree to follow strict privacy and security policies. Technology will encrypt (scramble) the information and track who and when someone has accessed your summary. You may request a list from your doctor's office of who has accessed your electronic records.

Dr Dennis is asking permission to share your vital medical information through the eEHX Summary for all legally permitted uses and disclosures. These include but are not limited to:

- Clinical Care
- Billing and financial management
- Administrative management
- Reports to public health agencies and other governmental requirements
- Reports to protect the security of your medical information
- Reports to evaluate the use of the eEHX Summary
- Reports to track and evaluate the quality of your healthcare services

____Yes, I want my health information included in the Collaborative eEXH Summary as described above. By my signature below:

I acknowledge that I have been given sufficient information and have had the opportunity to have my questions answered about the eEHX Summary.

I give permission to those described above to use and disclose my information, as described above.

I understand that I have the option to withdraw my permission and can do so by giving written notice to my doctor's office. Should I withdraw my permission, this request will be effective within one business day of my written notice.

_____ _____

Signature of Patient/Representative Date

____No, I do not want my information included in the Collaborative eEXH Summary.

I understand that my information will still be stored electronically for my provider's records, but an eEHX Summary will not be available to other providers. I also understand that without the eEHX Summary, it may be more difficult for doctors and healthcare providers to coordinate my care. This could have an adverse effect on the quality and efficiency of my health care services.

_____ _____

Signature of Patient/Representative Date