Participation in the Health Information Network
Authorization and Consent Form

What are you agreeing to by signing this form?

- To give your permission to allow your health care providers to share your health records electronically, through their computers, to better care for you.
- That you have received information about sharing your health records through the Health Information 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 Mercy participates in my state's Health Information Network. Mercy and other participants in my state's Health Information Network:

1. Will be able to see all of my health records from both before and after today's date.
2. 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.
3. 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 that I am taking or have taken

   This also may 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
   - Head and spinal cord injuries
   - Family planning information (including abortions)
   - Sexually transmitted diseases
4. May copy or include my health information in their own medical records when caring for me. Even if I later cancel my consent, providers I've visited who have copied my records are not required to remove them. This is the current law.
5. Have penalties in place for anyone sharing my data in the wrong way.
6. The Health Information Network will keep track of who views my health records to make sure they are secure. I can ask my doctor or the Health Information Network for a list of who has looked at my records.

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I also understand and agree that:

1. Using my health information for marketing or advertising purposes, or to determine insurance or employment eligibility is ***strictly prohibited***.
2. My consent will remain in effect until the day I cancel my account by "Opting Out" or the Health Information Network no longer exists, whichever comes first. If I suspect or learn that my health information was accessed in the wrong way, I can find information at the following websites:
   - Missouri http://www.missourihealthconnection.org/consumers
   - Kansas http://www.khinonline.org/for-patients2/consumers
   - Oklahoma http://www.smrtnet.org/for-patients ***or*** http://www.coordinatedcare-ok.com/
   - Arkansas http://ohit.arkansas.gov/consumer/Pages/default.aspx
3. My consent to join the Health Information Network is voluntary.
4. This form replaces all previous Health Information Network consent and opt-out forms for my state that I have completed before today.
5. I may ask for a copy of this form after I sign it.

By signing this form, I give all Health Information Network participating providers the right to share all of my health records, including sensitive data, through the Health Information Network's Network for purposes of providing care to me.

My Name (*print please*) My Date of Birth

My Address I City I State I Zip Code

My or My Legal Representative's Signature* Date of Signature

Printed Name of Legal Representative (*if applicable*) Relationship of Legal Representative (*if applicable*)

**If I am the parent or guardian of a child, I can consent on behalf of the child only until he or she turns 18. At that time, the child will be automatically opted out unless he or she chooses to join the Health Information Network.*