Missouri Health Connection Authorization and Consent Form

February 2017

Who is this form for?

It is for patients who want to join the Missouri Health Connection (MHC) health information network.

What are you agreeing to by signing this form?

- To give consent that allows your healthcare 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 MHC 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 MHC and healthcare providers participating in the MHC Network:

1. Will share my health data with providers who are treating me.
2. Will be able to see all of my health records from both before and after today's date.
3. 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.
4. 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 I am taking or have taken

    This may also 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
    - Family planning information (including abortions)
    - Sexually transmitted diseases
    - Head and spinal cord injuries
5. May copy or include my health data 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.
6. Have penalties in place for anyone sharing my data in the wrong way.
7. MHC will keep track of who views my health records to make sure they are secure. I can ask my doctor or MHC for a list of who has looked at my records. List of Current Providers: missourihealthconnection.org

What is Missouri Health Connection (MHC)?

MHC is the nonprofit, health information network for Missouri. This secure, electronic network allows your doctors and other caregivers to share your health records quickly to provide you with the best care.

Who has access to the MHC Network?

Only authorized health care providers/organizations and professionals involved in your treatment, coordination of care, quality improvement and activities related to management or payment of your healthcare. Medical record information is protected under federal and state privacy laws; access, use and disclosure of medical records will comply with the laws.

Please read and understand each of the following statements:

- Using this data for marketing or advertising purposes, or to determine insurance or employment eligibility, is strictly prohibited.
- My consent will remain in effect until the day I cancel my account by "Opting Out" or MHC no longer exists, whichever comes first.
- My consent to join MHC is voluntary. I can cancel my consent at any-time. I can rejoin at any time.
- I may ask for a copy of this form after I sign it.
- If I suspect or learn that my data was shared or accessed in the wrong way, I may contact MHC at: info@MissouriHealthConnection.org or PMB 270, 2000 E. Broadway, Columbia, MO 65201-6091.

Patient Information:

By signing this form, I give all MHC participating providers the right to share all of my health records, including sensitive data, through MHC's Network for purposes of providing care to me. MHC has the right to contact me do identity verification.

____ ________/______/_______

My Name (print please) (include maiden name) Date of Birth

____ ______________________

My Address City

____________ ____________ __________ ________/_______/________

State Zip Code Gender Social Security

Patient Signature:

X____ ______/_______/______

Patient or Guardian Signature **Date**

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 MHC network.

This area is to be completed by a Notary Public

The foregoing instrument was acknowledged before me, a Notary Public, on_______/_____/______(date) by ____(patient name), known to me to be the person whose name is subscribed to the within instrument & acknowledged that he/she executed the same for the purposes therein contained.

Notary Signature:_____________________________________State:_______County: ________________

Submission Instructions: Notary Stamp:

Mail to: Missouri Health Connection
PMB 270
2000 East Broadway
Columbia MO 65201