

## Details About Your Health Information in BayCare eHX and the Consent Process:

- How Your Health Information Will Be Used:** Your health information will be used by members of the BayCare eHX only:
  - To provide you with medical treatment and related services
  - To check whether you have health insurance and what it covers
  - To evaluate and improve the quality of medical care provided to all patients
  - For administrative management of the BayCare eHX
- What Types of Health Information About You Are Included:** If you give consent, members of the BayCare eHX may access **ALL** of your health information available through the BayCare eHX. This includes information created before and after the date of this Consent Form. Your health information available through the BayCare eHX will include all of your demographic, insurance and medical information. For example, your health information may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. As part of this Consent Form, you specifically consent to the release of health information that may relate to sensitive health conditions, including but not limited to:
  - Substance abuse
  - HIV/AIDS
  - Psychiatric/mental health conditions
  - Birth control and abortion (family planning)
  - Genetic (inherited) diseases or tests
  - Sexually transmitted diseases
- Where Health Information About You Comes From:** Health information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid/Medicare program and other health organizations that exchange health information electronically.
- Who May Access Information About You, If You Give Consent:** Access to the BayCare eHX will be limited to only those members of the BayCare eHX who have agreed to use the BayCare eHX consistent with your permission as set forth in this Consent Form and who have agreed to the overall terms and conditions established for use and operation of the BayCare eHX.
- Improper Access to, or Use of, Your Information:** If at any time you suspect that someone who should not have seen or received access to your health information has done so, please contact the BayCare Privacy Department at (727) 820-8024.
- Re-disclosure of Information:** Any electronic health information about you may be re-disclosed by members of the BayCare eHX to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. You understand that the protected health information disclosed pursuant to this Consent Form may not be protected by federal law once it is disclosed by your physician.
- Effective Period:** This Consent Form will remain in effect until the day you withdraw your consent.
- Withdrawing Your Consent:** You can withdraw your consent at any time by giving written notice to Chris Eakes, Manager of eHX, BayCare Health System, 17757 U.S. Highway 19 N., Suite 500, Clearwater, FL 33764. Organizations that access your health information through the BayCare eHX while your consent is in effect may copy or include your health information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove your health information from their records.
- Copy of Form:** You are entitled to get a signed copy of this Consent Form after you sign it.

## Consent to Share My Health Information With the BayCare Electronic Health Exchange

The BayCare Electronic Health Exchange (**BayCare eHX**) is an exciting program designed to improve your health care and make office visits easier and more convenient. This authorization will allow all of your doctors participating in the BayCare eHX to enroll you in the BayCare eHX and to disclose your demographic, insurance and medical information (collectively, your "**health information**") to the BayCare eHX so that it can be shared with other providers of healthcare, including doctors, nurses, health professionals, hospitals and other health care facilities. Only health care providers and authorized personnel that participate in the BayCare eHX, and others whose job it is to maintain, secure, monitor and evaluate the operation of the BayCare eHX, will be able to access your health information. The BayCare eHX will allow your providers access to your health information more quickly and accurately than with paper charts.

You may use this Consent Form to decide whether or not to allow the BayCare eHX to see and obtain access to your health information in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. Your choice will not affect your ability to get medical care or health insurance coverage. **Your choice to give or to deny consent may not be the basis for denial of health services. However, to the extent you have denied consent, you understand that your health information will not be available to other providers on the BayCare eHX for your medical treatment.**

If you check the "**I GIVE CONSENT**" box below, you are saying "Yes, members of the BayCare eHX may see and get access to all of my health information through the BayCare eHX."

If you check the "**I DENY CONSENT**" box below, you are saying "No, members of the BayCare eHX may not be given access to my health information through the BayCare eHX for any purpose."

**Please carefully read the information on the back of this form before making your decision.**

**Your Consent Choices:** You can fill out this form now or in the future. You have two choices:

**YES, I GIVE CONSENT for my doctors to enroll me in the BayCare eHX and for the members of the BayCare eHX to access ALL of my health information as set forth in this Consent Form.**

**NO, I DENY CONSENT for my doctors to enroll me in the BayCare eHX and for the members of the BayCare eHX to access ALL of my health information as set forth in this Consent Form.**

\_\_\_\_\_  
Printed Name of Patient/Representative

\_\_\_\_\_  
Signature of Patient/Representative

\_\_\_\_\_  
Date

AUTHORITY OF REPRESENTATIVE:

I, \_\_\_\_\_, do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis: \_\_\_\_\_

\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_