10175

Care New England

REQUEST TO RESTRICT DISCLOSURE OF PROTECTED HEALTH INFORMATION TO A HEALTH INFORMATION EXCHANGE (HIE)

FOR INPATIENTS: AFFIX PATIENT LABEL **OR** WRITE IN BOTH PATIENT NAME & MR NUMBER

FOR OUTPATIENTS: WRITE IN BOTH PT NAME & DOB

PATIENT NAME: ______________________________

DOB OR MR #: ______________________________

A Health Information Exchange (HIE) allows doctors, nurses, pharmacists, other health care providers and patients to appropriately access and securely share a patient's vital medical information electronically—improving the speed, quality, safety and cost of patient care. It is the policy of CNE to share your health information, for treatment purposes, with other health care providers using a HIE unless you chose to restrict CNE from sharing your health information. The purpose of this form is to give you the opportunity to restrict CNE from sharing your information on one or all participating HIEs.

In making your decision whether or not to restrict sharing, consider the positive benefits of having your health information available through a HIE. HIEs are aimed at improving the coordination and quality of health care services you receive. Health information provides healthcare providers and medical staff with a quick snapshot of your current and past health so that they can make informed decisions about your care. This is valuable in an emergency situation if you cannot communicate with them.

Having this information quickly available also reduces the need for unnecessary testing and can minimize medical errors.

Only authorized participants have secure access to your medical records through these health information exchanges. These participants may ONLY access data for purposes of treatment and care coordination which promote efficiency of communication in care, patient safety, and enhance patient health. These participants also have to abide by HIPAA privacy and security standards. Use of an HIE for any other reason is strictly prohibited.

If you decide you do not want your health information or your minor child's health information made available through a CNE sponsored HIE, mail or fax this form to the address or fax number below. Please note that any information that has been released prior to this document being accepted cannot be retracted.

Keep a copy of this form for your records. If you decide later that you want to make your health information available through one of more CNE sponsored health information exchanges, you must complete a form to request to withdraw this request.

NOTE: If you are enrolled in the Rhode Island HIE, CurrentCare, and wish to un-enroll you must complete a cancellation of Participation form which can be found on Currentcareri.com under Member Forms, contact Rhode Island Quality Institute at 50 Holden St, Suite 300, Providence Rhode Island 02908 or 1-888-858-4815.

Request to Restrict Disclosure of Protected Health Information to a Health Information Exchange (HIE)

By signing this form, I acknowledge:

- I do not want my health information (or the health information of my child) shared through the Health Information Exchange to all health care providers involved in my care that participate in or is connected to the HIE.
- If I wish to no longer participate in CurrentCare, I must also contact the Rhode Island Quality Institute directly.
- This revocation only applies to the sharing of health information through the HIE. My health care providers may still have access to my health information using other methods, such as fax, telephone, email or mail.
- Any information that was shared through the HIE before the date this form is processed will remain available to providers who request access.
- This request to opt out of the HIE will be effective ***2-5 business days*** after the receipt by CNE to process my request to prevent sharing of my health information through a CNE HIE.
- I may opt back into sharing my health information through the HIE by revoking this form. I can make this request at any CNE provider location or by contacting Health Information Management.

All sections must be completed (please print):

Patient Legal First Name	Middle Initial	Legal Last Name
Other names you have used (maiden name, etc.)		
Street Address		
City	State	Zip
Phone #	Date of birth (mm/dd/yyyy)	
Patient/Guardian/Personal Representative Name (printed)	Relationship to Patient	
Patient/Guardian/Personal Representative Signature	Date	

Mail to the attention of Health Information Management:

Butler Hospital: 345 Blackstone Blvd. Providence, RI 02906 — Fax: (401)-455-6498
Kent Hospital: 455 Toll Gate Road, Warwick, RI 02886 — Fax: (401) 736-1004
The Providence Center: 530 North Main St, Providence, RI 02904 — Fax: (401) 276-4024
Visiting Nurse Association: 51 Health Lane, Warwick, RI 02886 — Fax: (401) 736-4228
Women & Infants: 101 Dudley St, Providence, RI 02905 — Fax: (401) 453-7734
CNE Medical Practice: To the practice location in which you receive services

CNE INTERNAL USE ONLY:

Restrict Request Processed on (date):	Received By:

I am requesting to **revoke prior restriction** (as noted above) placed on the use or disclosure of my health information to the HIEs

Date/Time: ____________________________ Patient/Legal Guardian signature: ________________________________

Relationship to Patient: ____

CNE INTERNAL USE ONLY:

Recind Request received (Date): ________________________ Received By: ___________________________________