Child & Family Agency of Southeastern Connecticut, Inc.

AUTHORIZATION FOR HEALTH INFORMATION EXCHANGE

The Health Information Exchange (HIE) system is a secure computer system that brings your protected health information (PHI) from different healthcare locations into one nationwide electronic health record. The HIE system network provides participating practitioners access to past and present medical and behavioral health information to make better decisions and better coordinate care with your healthcare team. The HIE system takes your privacy and security very seriously. The HIE system does not store any of your health/clinical data and uses end-to-end encryption to help ensure your data is secure. Only those involved in your care can look at your information.

Person Receiving Services Legal Name*

First _____ Last _____

Date of Birth*: _____/ _____/ _____ (MM/DD/YYYY)

Medical Health and Sensitive PHI Information

The State of Connecticut participates in the **HIE,** meaning that **medical health information** (e.g. immunizations, medications, physical examinations, and psychiatric information, etc.) are shared with other medical providers unless a specific opt-out is received.

Additionally, **sensitive PHI** is PHI that is "subject to heightened confidentiality requirements in compliance with all federal and state laws as amended from time-to-time (e.g. HIV, substance abuse and mental health records).

Patients must specifically authorize disclosures of sensitive PHI.

- ○ I want to **opt-out** of any medical information and sensitive PHI being sent to other health care providers.*

By opting in, you can choose how your information is shared.

- ○ I opt-in for CFA to share information to the HIE.
- ○ I opt-in for CFA to receive information from the HIE.
- ○ I opt-in for CFA to share information to ***and*** receive from the HIE.

By signing below, I understand and acknowledge the following:

My sensitive health information will be available to providers using The HIE system.

I understand that refusal to sign this authorization form will not affect my right to obtain present and future services. I also understand that I may opt-out of HIE at any time by notifying CFA of the named recipient in writing.

Electronic signature of person authorizing health information exchange*

_____ Date: _____/ _____/ _____ (MM/MM/YYYY)

Relationship to Person Receiving Services*

- Self
- Parent
- Legal Guardian
    - Define: _____