eEHX Collaborative

Permission to Create an *eEHX Summary* and share My Medical Information

We are taking part in an exciting program to improve your health care and make office visits easier and more convenient. To do this, your doctor would like your permission to enroll you in our *eEHX Summary* program. This means sharing important parts of your medical information with other providers (doctors, nurses and health professionals) through an electronic medical chart. Only authorized healthcare professionals, their agents, and others whose job it is to secure, monitor, and evaluate the operation of the information system and quality of care would be able to access your information. The *eEHX Summary* will allow your providers to access your health information more quickly and accurately that with paper charts.

The *eEHX Summary* is an overview of vital medical information. For instance, the *eEHX Summary* may include a list of your current medications, allergies, recent diagnoses (problems) and any surgery you may have had. It will not include detailed confidential notes from your office visits. Information in the *eEHX Summary* may include, but is not limited to, that which South Carolina law considers "sensitive" such as mental health, substance abuse, sexually transmitted disease, and sexual abuse information. HIV/AIDS diagnoses and any genetic testing results for health screening purposes will not be included in the *eEHX Summary* without your written permission each time it is used.

The *eEHX Summary* has a security system to protect your healthcare information. All authorized healthcare professionals with access to the *eEHX Summary* agree to follow strict privacy and security policies. Technology will encrypt (scramble) the information and track who and when someone has accessed your summary. You may request a list from your doctor's office of who has accessed your electronic records.

Your doctor is asking permission to share your vital medical information through the *eEHX Summary* for all legally permitted uses and disclosures. These include but are not limited to:

- Clinical care
- Billing and financial management
- Administrative management
- Reports to public health agencies and other governmental requirements
- Reports to protect the security of your medical information
- Reports to evaluate the use of the *eEHX Summary*
- Reports to track and evaluate the quality of your healthcare services.

☐ **Yes, I want my health information included in the Roper St Francis Healthcare Collaborative eEXH Summary and described above and in the provided information sheet. By my signature below:**

I acknowledge that I have been given sufficient information and have had the opportunity to have my questions answered about the *eEHX Summary*.

I give permission to those described above to use and disclose my information, as described above and in the provided information booklet.

I understand that I have the option to withdraw permission and can do so by giving written notice to my doctor's office. Should I withdraw my permission, this request will be effective within one (1) business day of my written notice.

_____ _____

Signature of Patient/Representative Date

☐ **No, I do not want my information included in the Roper St Francis Healthcare Collaborative eEXH Summary.**

I understand that my information will still be stored electronically for my provider's records, but an *eEHX Summary* will not be available to other providers. I also understand that, without the *eEHX Summary*, it may be more difficult for doctors and healthcare providers to coordinate my care. This could have an adverse effect on the quality and efficiency of my health care services.

_____ _____

Signature of Patient/Representative Date

***Acknowledgement for Email Communication Consent Form**

4. <u>Patient Acknowledgment and Agreement</u>. I acknowledge that I have been provided a copy of the Email Communication Consent and fully understand this form. I understand the risks associated with the communication of e-mail between Rheumatology Associates and me, and I consent to the conditions outlined herein. I further agree to waive any and all claims that may arise against Rheumatology Associates, employees and representatives resulting from the use or misuse of E-mail. In addition, I agree to the instructions outlined herein as well as any other instructions that Rheumatology Associates may impose to communicate with patients by e-mail. Any questions I may have had were answered.

Patient Signature_____

Date_____

Email Address_____