WATSON CLINIC LLP
Quality Healthcare for Every Generation

WATSON CLINIC #

CONSENT FOR ELECTRONIC SHARING OF HEALTH INFORMATION

By signing this form, I authorize Watson Clinic LLP to exchange all of my protected healthcare information ("PHI") electronically through health information exchange systems ("HIE") including, but not limited to, regional and state health information exchanges, and software platforms such as Care Everywhere©, EpicCare, Carequality and Tampa Bay Regional Health Information Organization (RHIO), and other systems used to exchange PHI electronically. This includes all PHI contained in my electronic medical record, including medical history, diagnosis, treatment, examination, laboratory tests, and medications. I specifically authorize the exchange of my Sensitive Information through HIE as allowed on this form. Sensitive Information includes particularly confidential conditions such as mental health, psychological or psychiatric conditions; genetic information and related tests; drug, alcohol and/or substance abuse; HIV/AIDS, including tests for such conditions; sickle cell anemia; hospice care; birth control and family planning; and sexually transmissible diseases. PHI may be shared electronically through HIE with outside providers and entities, both inside and outside the United States, who request my information and indicate that they are involved in my care or treatment or are otherwise permitted by law to access my PHI. Even if I do not provide my consent below, Watson Clinic LLP may release my PHI electronically to treat an emergency medical condition when the health care provider is unable to obtain consent or the situation requires immediate medical attention.

I understand that I may request that my PHI no longer be shared through HIE by following the procedures outlined in the Notice of Privacy Practices for requesting restrictions. This authorization may be used to share all PHI maintained by Watson Clinic LLP, even if obtained before or after the date of this authorization. If Watson Clinic LLP grants my request for restriction, my revocation will be effective upon receipt by Watson Clinic LLP, but will not apply to any PHI already released as a result of this authorization and consent. I further understand that my PHI may contain information related to health plans, insurance benefits, worker's compensation programs, immunizations, educational programs, state programs and registries, and employers. I understand that my PHI shared per this authorization may be re-disclosed by the person or entity that receives it and, once shared, such PHI may no longer be protected by state or federal privacy laws if the recipient is not subject to those laws.

Watson Clinic LLP will provide me with a copy of this form upon request. I understand that I do not have to sign this form. If I do not sign, providers inside and outside Watson Clinic LLP may not be able to obtain my information through HIE, but it will not prevent Watson Clinic LLP from treating me. This consent expires ten (10) years after I am no longer a patient of Watson Clinic LLP.

Patient/Patient Representative Name	Date Signed
Signature	Relationship to Patient (if not signed by patient) ☐ Parent ☐ Legal Guardian ☐ Other (explain authority):

STAFF USE ONLY

☐ Accepted ☐ Declined

Received by: ______________________ Date: ____________
Name and Title

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