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## CONSENT FOR SHARING OF HEALTH INFORMATION

By signing this form, I authorize Watson Clinic LLP to receive, use, disclose, store, and exchange all of my Protected Healthcare Information (“PHI”) as explained in the Notice of Privacy Practices (“Notice”). I have received and read the Notice. The Notice describes how my PHI will be used and disclosed by Watson Clinic LLP, its staff, and other healthcare providers that work with Watson Clinic LLP. Disclosures may be made and used for treatment, payment, health care operations, and other purposes described in the Notice, and as otherwise permitted by law. Watson Clinic LLP may also obtain my information from other providers for those purposes. My PHI may be used by and shared within Watson Clinic LLP, as well as outside providers and other entities as explained in the Notice.

Watson Clinic LLP may exchange my PHI electronically through health information exchange systems (“HIE”). These HIE systems include, but are not limited to, regional and state health information exchanges, accountable care organizations (ACOs), regional health information organizations, software platforms, 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. Some HIE systems require Watson Clinic LLP to store data in the system, where it may be accessed by outside treating providers and other authorized persons. Watson Clinic LLP will also store electronic PHI in its own systems.

**I specifically authorize the exchange and disclosure of my Sensitive Information outside Watson Clinic LLP 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. Psychotherapy notes and certain information from federally regulated substance use disorder programs will be shared only as allowed by law. PHI may be shared electronically, orally, or on paper, 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; Watson Clinic LLP providers also share Sensitive Information internally as needed for treatment, payment, and health care operations.

Initial here if you read and agree to the paragraph above.

Patient or Patient Representative Initials **X** \_\_\_\_\_

Watson Clinic LLP may also release my PHI when required by law. 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. I understand that, once my PHI is shared as allowed on this form, Watson Clinic is not responsible for how those third parties use and disclose my PHI. **I understand that I may request that my PHI, including certain Sensitive Information, no longer be shared by following the procedures outlined in the Notice of Privacy Practices for requesting restrictions.**

Patient/Patient Representative Name (PLEASE PRINT)	Date Signed
Signature	Relationship to Patient (if not signed by patient) <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other (explain authority):

**STAFF USE ONLY**

Accepted     Declined

Received by: \_\_\_\_\_ Date: \_\_\_\_\_  
*Name and Title*