

## Consent for Electronic Health Information Exchange (HIE)

I consent to Children's Minnesota and my providers to electronically obtain and share my/my child's health care information for coordinating my/my child's care and treatment.

This consent permits Children's and its providers to: 1) electronically request and obtain my/my child's health records from other health care providers that have provided care and treatment to me/my child; and 2) make my/my child's Children's medical records available electronically to other health care providers who provide care to me.

These records may include testing, diagnosis, treatment, demographic and registration records created in the course of providing services to me for all medical and health conditions, including but not limited to, family medical history, patient and/or family histories of behavioral and mental illness, developmental disabilities, recreational or illicit drug use/abuse/ dependency, sexually transmitted illnesses, or other items of a social history nature.

If you have specific requests for how your/your child's health information should be used or disclosed those requests may not be shared through the electronic health information exchange. You should discuss those specific requests with your other health care providers.

### Provider Record Locator

A health record locator service helps your health care provider determine where you have received care. I consent to Children's and my providers to access my information in a record locator. I also consent to Children's and my providers making my information available in a record locator to be searched by other health care providers that may provide me care and treatment.

If you do not want Children's and your providers to utilize a record locator for accessing and sharing your health information you must check this box.

You may cancel or revoke this consent by writing to: Health Information Management, Children's Minnesota, 5901 Lincoln Drive (Mail Stop CBC-2-HIM) Edina, MN 55436. If this consent is canceled or revoked, it will not change releases that have already occurred prior to receiving your written cancelation.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Telephone consent obtained by (Name/Date/Time): \_\_\_\_\_



PLACE PATIENT LABEL HERE