Allegheny Health Network

Please send your completed form to the Allegheny Health Network Department of Data Integrity.

Mail to: Health Information/Medical Records
Attn: Data Integrity
1301 Carlisle Street
Natrona Heights, PA 15065

Fax to: 724.226.7494

Email to: dataintegrity@ahn.org

Consent to Share Information with Health Information Exchange and other Covered Entities

Patient Name: _____ Date of Birth: _____

Allegheny Health Network (AHN) understands that you may receive medical care from our healthcare professionals and from healthcare professionals outside of our network, including non-AHN providers using our electronic medical record platform to support their treatment activities. To ensure that your treating providers have complete and accurate medical information about you, AHN participates in a Health Information Exchange (HIE) and transmits information to the HIE and your non-AHN providers through automated processes. This information sharing allows your treating providers to coordinate and provide quality medical care, particularly during emergencies.

AHN is committed to protecting your privacy and confidentiality and uses secure means to share your information.

Please be advised that this consent form only applies to automated data transfers to the HIE and your non-AHN providers regarding the information listed below. All health information not included below may be shared in accordance with our Notice of Privacy Practices.

You understand the nature of your release and hereby consent to and acknowledge the following:

- By signing this form, your treating providers outside of AHN may request, view, print, and store your health information listed below with secure means. If you are physically unable to sign, you may consent orally if witnessed by two (2) staff members.
- Health information that may be shared may include the following: the evaluation, diagnosis, and/or treatment of
  - Drug and/or alcohol abuse and/or dependence
  - Mental health
  - HIV/AIDS
- This consent does not expire; however, you can revoke it and opt out of information sharing at any time. To opt out, you must request an *Opt Out of Information Sharing with Health Information Exchange and other Covered Entities* form from your provider's office or AHN's Data Integrity department using the contact information provided above. Any of your electronic health information listed above that is disclosed before you opt out cannot be taken back.
- Your treatment will not be affected in any way, whether you sign or do not sign this form. You are not required to sign this form to receive treatment.
- A disclosure statement will accompany your shared electronic health information listed above, as required by state and/or federal law.

If you are 14 years old or older, please sign and date here.

_____ _____
Patient Date and Time

If the patient is under 18 years old and not emancipated, or if the patient is unable to sign this form, a parent or legal guardian must also sign and date here.

_____ _____
Parent or Legal Guardian Date and Time

_____
Relationship to Patient

Allegheny Health Network is a participant in an Organized Health Care Arrangement comprised of hospitals, ambulatory surgery centers, and primary and specialty care physician practices that may share your protected health information, and medical information of others we service, for the health care operations of our joint activities.
Rev. 1/2018.

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Allegheny Health Network or external provider employee acting as witness must sign and date here. For persons physically unable to sign, two (2) witness signatures are required.

Witness _____ Date and Time _____

Witness _____ Date and Time _____