Advocate Physician Partners

Notificaton: Re-Opt In to eEHX Form-

Electronic Health Information Exchange and/or Illinois' Immunization Registry

_____YES. I do want my Health Information included in the electronic Health Information Exchange as described above.

I acknowledge that I was given sufficient information and that I had the opportunity to have my questions answered regarding the electronic Health Information Exchange program.

I understand by signing this notice and submitting it to the practice manager of my physician's office that I am giving permission to share my Health Information.

This permission may take affect starting with your current physician's visit and will not expire unless by your written request or if the electronic Health Information Exchange program is discontinued. Any withdrawal of permission will be effective on the day of retraction by the physician's office, except to the extent that action already has been taken in reliance on this permission.

I understand that my eligibility for treatment or any healthcare benefits cannot be conditioned on whether I sign this permission. However, to the extent that I have now indicated "YES" to sharing of my Health Information, I understand that an electronic Health Information Exchange record will be available to other providers.

_____YES, I request that my immunization information be added to the Illinois Immunization Registry. I understand the state will start to share immunization data on me with the registry as a result of this action. The registry will contain core demographic information necessary to identify that I have chosen to opt in to the registry. This information is necessary for the registry to be able to filter and allow the use of immunization information for me. Additionally, any prior immunization records associated with me will not be shared from the registry. To opt out, a separate opt out form must be completed.

_____
Printed Name of Patient/Representative

_____ _____
Signature of Patient/Representative Date

AUTHORITY OF REPRESENTATIVE:

I, _____, do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis:

Relationship to Patient: _____

[A signed copy of this permission will be provided to the patient/representative. **Please place a copy of this form in the patient's medical chart.]**

17-8209