Doctors affiliated with Beth Israel Deaconess Medical Center (BIDMC) and other doctors who participate in the Beth Israel Deaconess Care Organization (BIDCO) participate in a **Health Information Exchange (HIE).** The HIE is a secure computer network that, with my permission, will allow my BIDMC and BIDCO providers to view all of my health information (medical records). The HIE protects the confidentiality, privacy and security of the information. By making my health information available electronically, my BIDMC and BIDCO providers will be able to better coordinate my care. By signing this form, I give my permission to my BIDMC and BIDCO providers to view my health information electronically via the HIE.

I understand that my health information may contain (now or in the future) certain types of sensitive information:

- HIV/AIDS status
- genetic testing
- treatment for substance abuse (alcohol or drug)
- venereal disease(s)
- mammography records
- family planning services
- confidential communications with a psychotherapist, psychologist, social worker, sexual assault counselor, domestic violence counselor or other allied mental health professional or human services professional
- if I am an emancipated minor, information about my treatment and diagnosis (but not shared with my parents)
- All billing disclosures and collection matters

By signing this form, I agree to the release of *all* my health information, including sensitive information, to my BIDMC and BIDCO providers through the HIE.

If you do not wish for sensitive information to be released in connection with the HIE, please do not sign this consent below. Initials _____

I understand that BIDMC, BIDCO, and my health care provider have taken reasonable steps to protect my confidentiality.

This Authorization will stay in effect from the date of my signature below until my provider is no longer participating in the HIE. I have the right to take back my consent (revocation), in writing, at any time. My revocation will be effective when my provider receives it. I may also contact my provider's Privacy Officer by mail at [insert address], by telephone at [insert number] or by email at [insert email address].

I have read this Authorization form and I understand what it says. All of my questions have been answered in a language that I understand. I agree with the information on this form. By signing this form I authorize my health care provider to use or disclose my health information in order to participate in the HIE.

_____ _____

Signature of Patient «encDate»

If the patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

_____	_____	_____
Signature of Authorized Personal Representative	Relationship to Patient	Date