ARROYO VISTA FAMILY HEALTH CENTER



Patient Name _________________________ MRN: _______________________

Gender M F Date of Birth____________________________

**Health information Exchange consent form**

Please use this form <u>only</u> if you wish to change your current consent status for your permission to allow LANES and Care quality to share your information with clinicians who have a test or treatment relationship with you.

Please check the box next to your choice changing your status to be in the Health information Exchange. Please Sign the form at the end. Each family member should fill out a separate form.

☐ **Choice 1:** **I do <u>not</u> agree** to have my medical information viewed in the Exchange.

☐ **Choice 2:** **I want to change an earlier decision not to join the Exchange.** I now agree to have my medical information viewed in the Exchange. This may include information from before today's date.

**Please sign here:**

Signature ____________________________________Date________________________________

**Complete this information only if you have signed the form for another person:**
Do you have the authority to make health care decisions on behalf of the patient? ☐ Yes ☐ No

What is your relationship with the patient? __________________________________________

This section for office use only:

Verified by: ___________________________________________________
Signature of verifying staff: _________________________________
Date: ___________________________________________________________