Request to Change Consent

KING'S DAUGHTERS

I understand that my treating providers have access to my medical records through the CliniSync Health Information Exchange.

If you **do not** want to have your records shared, please mark the box below.
❑ **I don't want to have my records shared on a health information exchange.** I understand that my test results and medical information will not be accessible to health care providers (including emergency room physicians) through CliniSync. I understand that I may choose to participate in CliniSync again at any time.

If you previously said that you didn't want to have your records shared and **now want** them shared, please mark the box below. This will allow your status to be changed.
❑ **I consent to have my records shared through the Health Information Exchange. I have read this form. I have had a chance to ask questions. I am satisfied with the answers.**

First Name: Middle Name: Last Name:

Previous Last Name: Date of Birth: Gender: ❑ Male ❑ Female

Street Address:

City: State: Zip Code:

Phone: Mobile:

Email Address:

Last four digits of Social Security Number:

Patient Signature: Date:
(If under the age of 18, signature of parent or legal guardian)

If signed by a legal guardian or power of attorney, please attach copies to this form.

OPTIONS FOR SUBMISSION

Option 1: Complete the top portion of this form and submit to your medical provider's office staff, hospital or other KDHS facility. Please allow two business days for processing your request.

For KDHS Use Only

Please fax completed form to (606) 408-6609. Call (606) 408-9370 to confirm receipt of fax.

Option 2: You can complete this form, have it notarized and mail it to:
Attn: CONSENT STATUS, Ohio Health Information Partnership
3455 Mill Run Drive, Suite 315
Hilliard, OH 43026

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Section to be completed by a Notary Public:
I witnessed the above named individual sign this document and the individual is personally known to me, or provided me with valid picture identification on this day _____ of _____, 20_____ .

Notary Public (Print Name):_____

Phone:_____

Notary Public Signature: _____

March 2017