CHILDREN & TEENS MEDICAL CENTER

IILINOIS IMMUNIZATION REGISTRY: This practice participates with the Illinois State Immunization registry & Public Health Disease Surveillance registry. Information will be sent electronically to the IL State registries about immunizations and state-required reportable diseases. This information is used by the State of Illinois to track Public Health needs.

ELECTRONIC HEALTH EXCHANGE:

YES, I authorize this practice to use and/or disclose a copy of my Childs protected health information in the Electronic Health Information Exchange (eEHX) for the purpose of coordinating my medical care amongst my Childs healthcare providers. I understand that including this information in eEHX enables any provider with authorized access to the eEHX to review my protected health information. The information in eEHX includes your child (ren) demographic information such as name and gender, diagnostic assessments, medications, immunizations, lab results, diagnostic imaging results, referrals and procedures. The patient summary will also be shared and includes advanced directives, allergies, surgical history, hospitalization history, family history and treatment plans.

I understand that future withdrawal of permission to include this information in the Electronic Health Information Exchange (eEHX) will be effective except to the extent action has already been taken in reliance on this permission. When I withdraw my Childs protected health information will be inactivated and the eEHX and will no longer be able to be accessed. This permission will expire if the eEHX program is discontinued.

I understand that my Childs eligibility for treatment or any other health care benefits cannot be conditioned on whether I sign this authorization form. However, to the extent I have indicated "YES" to the sharing of my Childs protected health information, I understand that an electronic Health Information Exchange record will be available to other eEHX authorized users. The physicians' and nurse practitioner of Children & Teens Medical Center have authorization to disclose and implement eEHX. Office Managers will have authorization only through the physicians and nurse practitioner at their discretion.

By signing below I acknowledge and consent to all of the above sections specifically named. I understand and agree to the above statements.

X _____ Date: _____

Signature of Parent/Guardian/Custodian/Non-Custodian