CenterWell ACE

Authorization to Disclose and Retrieve Information To/From Health Information Exchanges (HIEs)

******ONLY FOR PATIENTS IN FLORIDA******

Patient Name: _____ Date of Birth: _____

Address: _____

Who May Disclose and Retrieve My Information:
By signing this form, I authorize CenterWell ACE entities, including CenterWell Senior Primary Care and Conviva Care Centers (collectively, "**CenterWell**"), to exchange my protected health information (PHI) electronically through all local, regional and state-wide health information exchange systems (HIEs). CenterWell may disclose and retrieve PHI to or from other healthcare professionals, healthcare organizations, hospitals, laboratories, radiologists, and pharmacies participating in the HIEs. I understand that HIEs are required to maintain appropriate safeguards to protect the privacy and security of my PHI and that only authorized individuals may access my health information from the HIE.

Benefits of HIEs:

- Allows your healthcare providers to quickly access your PHI to give you the best care possible, versus traditional methods such as telephone, fax, or mail—which may slow down decisions on your care.
- As your information becomes available, the HIE will quickly send your data to your providers. A complete medical history lets your provider make faster and more correct choices when caring for you.
- When your providers share your medical history, they can manage your care better. Specialists will have information they need faster. Emergency room staff can care for you even if you cannot answer questions.
- Removes burdensome practices such as unnecessary/repeated tests, bringing x-rays or other tests results to a referral appointment, and having to remember your medical history or current list of medications.

What May Be Disclosed – *Please read carefully*
All information relating to my health that is collected or maintained by CenterWell. This may include but is not limited to: progress notes; insurance/claims data; treatment plans; procedures; labs; imaging (x-ray, EKG, etc.); immunizations; and pharmacy/prescription data. **I understand and affirm that by providing consent and signing this form, I give express and informed consent for the release of all sensitive information which *may* be contained in these records, including but not limited to**: **sexually transmitted or communicable diseases; HIV/AIDS, (includes test results & treatment); substance, alcohol, or drug abuse; mental impairment(s), developmental disabilities, and behavioral health (except psychotherapy notes), including hospital confinements for physical and mental conditions; genetic information/testing; and other related conditions.**

Purpose: The purpose of this authorization is to allow for the exchange of my PHI electronically through HIEs so that it may be accessed by my providers outside of and within CenterWell for purposes of treatment, payment, and health care operations, and as otherwise permitted or required by law. This authorization may not be used for any purpose prohibited by law, including, without limitation, discrimination prohibited by federal or state law.

Expiration: This authorization is valid until the earlier of the occurrence of the death of the patient, or in **36 months** from the date of signature.

I UNDERSTAND THAT:

- Informed written consent is valid until revoked. I may revoke my consent at any time and for any reason by providing written notice of the revocation to CenterWell. CenterWell shall communicate the revocation to the HIE.
- Signing this authorization is **voluntary**. Treatment, payment, enrollment, or eligibility decisions will not be conditioned upon my decision to sign this form, except as authorized by federal privacy regulations.
- Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and may no longer be protected by federal or state privacy laws.
- Refusing to sign this form does not stop disclosure of protected health information that is otherwise permitted by law without my specific authorization or permission.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses, releases, and disclosures of my protected health information as described.

Signature of Patient or Patient's Legally Authorized Representative*	**Date**

Printed Name of Legally Authorized Representative (if applicable)	**Date**

*If representative, describe your authority to act for this individual and provide any corresponding documentation (guardian, power of attorney, healthcare surrogate, etc.): _____