Vale-U-Health Regional Health Information Organization (VUH RHIO)
Health Information Exchange (HIE)
Opt-In Form

By consenting to participate in the Vale-U-Health RHIO Health Information Exchange (the HIE), I am consenting that my participating health care providers may access my medical records through a computer network operated by Vale-U-Health Regional Health Information Organization (RHIO). Vale-U-Health is a non-profit organization comprised of Monongahela Valley Hospital, Inc. and physician practices on staff at the hospital.

The purpose of the HIE is to share health information electronically and securely to improve the quality of health care services. VUH RHIO believes that electronic exchange of health information can help improve the quality of health care services by giving providers prompt access to a complete medical history, by having medical information available during an emergency situation and by helping to minimize unnecessary duplication of diagnostic tests.

By consenting to participate in the HIE, I agree that information about me may come from places that have provided me with medical care or health insurance. These places may include hospitals, physicians, pharmacies, clinical laboratories, health insurers and other electronic health organizations that exchange information.

By consenting to participate in the HIE, I understand the purpose of the electronic disclosure of my medical and health information is to facilitate my medical treatment, arrange for payment for health care services provided to me and for other administrative purposes (called "health care operations") by the participants in the HIE. I understand the information to be disclosed includes medical records used to make decisions about me including the following kinds of Protected Health Information:

Demographic (name, age, address, etc)
Medical (diagnosis, treatment history, referrals to other providers, etc)
Encounter Data (description of services provided)

By consenting to participate in the HIE, I allow all HIE participating health care providers to access and share my medical information for treatment, payment and health care operation purposes.

Important. Pennsylvania state law requires your specific consent prior to the release of certain sensitive health information about you. Except as otherwise permitted or required by Pennsylvania law (e.g., for public health reporting purposes), you must initial the following statement showing that you authorize the disclosure of all types of this sensitive information to the extent permitted by Pennsylvania law applicable to the treatment of:

_____ alcohol or drug abuse problems, HIV/AIDS, mental health conditions, sexually transmitted diseases, genetic (inherited) diseases or tests

Blanket Consent. By choosing to initial the above categories of sensitive health information, I intend to the maximum extent permitted by applicable law for my consent to operate as a blanket or standing consent for all disclosures and acknowledge that this blanket consent is intended to provide evidence of my consent for each disclosure unless and until I revoke my consent as provided below.

By consenting, I understand that the information contained in the HIE may be shared with some HIE participants by means of transmission through other health information exchanges for treatment, payment and health care operation. Information will not be re-disclosed for other purposes outside of the health information exchanges without my written authorization.

All participating providers have agreed to a set of standards relating to their use and disclosure of health information available through the HIE. These standards are intended to comply with applicable federal and state laws related to privacy and confidentiality of protected health information.

Revocation: I understand that I may revoke this Consent by sending a written and dated notice to Vale-U-Health RHIO Administrator, WillowPointe Plaza 800 Plaza Drive suite 230, Belle Vernon, PA 15012. My revocation of this Consent will not affect any uses or disclosures made prior to the acceptance of my revocation. I understand that with the effective date of the revocation, all patient data from that date forward will not be transmitted to the HIE and all data that existed prior to the revocation will be hidden from view. I understand that providers that accessed my health information through the HIE while my consent was in effect may have copied or included my health information in their own medical records and are not required to return or remove my health information from their records.

Disputes. I understand that the HIE is an innovative technology that may contribute to improving my health care services. In the event of a dispute, grievance or claim of any amount or type by me arising from the operation of the HIE or the disclosure of my health information by means of the HIE, I agree to first submit any such grievance to a dispute resolution process afforded by VUH RHIO and pursue only those claims involving gross negligence

By signing this consent form, I acknowledge that I understand the contents of this document and have had the opportunity to ask questions and have those questions answered to my satisfaction.

Signature of Patient or Representative Authorized to Permit Disclosure

_____ _____

Signature Date

AUTHORITY OF REPRESENTATIVE:

I, _____, do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis: _____

_____

_____

Relationship to Patient:_____