☐ Hoag Medical Group ☐ Hoag Urgent Care ☐ Hoag Physician Partners ☐ Hoag Concierge Medicine ☐ Hoag Specialty Clinic ☐ Hoag at Home

HEALTH INFORMATION EXCHANGE AUTHORIZATION

The Hoag entity selected above and affiliates participates in a Health Information Exchange called Care Everywhere. Care Everywhere is aimed at improving the coordination and quality of health care services you receive by providing your health care providers with information regarding your current and past health. This allows your health care providers to make more informed decisions about your care and helps to reduce medical errors and duplicate tests.

By completing and signing this Authorization, I authorize the Hoag entity selected above and affiliates to disclose my health information, for the purposes and to the recipients designated in this Authorization.

Patient Information:

Name: _____ Date of Birth: _____

Purpose of Disclosure and Recipient(s): By signing this Authorization, I authorize past, present or future members of my care team through Care Everywhere to disclose my health information for purposes of enabling members of my care team to provide medical care and treatment to me. The term "treatment" includes activities related to the provision or coordination of health care and related services by one or more members of my care team, including referral or consultation for any condition for which I may receive care.

Information to be Disclosed: All information that the Hoag entity selected above and affiliates maintains about me from any and all dates of treatment or service, including without limitation, encounter information, visit notes, discharge summaries, care plans, laboratory, operative, or pathology results, allergies, medications, problem lists, immunizations, and procedures. This will include information relating that may be particularly sensitive to me, including mental health information, HIV/AIDS test results and information, genetic information, and STD treatment information.

I understand and agree that:

- This Authorization is voluntary. If I do not sign this Authorization, it will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits at the Hoag entity selected above and affiliates. However, I understand that my refusal to sign this Authorization will not affect the Hoag entity selected above and affiliates ability to disclose my information through Care Everywhere where my Authorization is not required by applicable law.
- I may revoke or cancel this Authorization at any time by submitting a written request to the Hoag entity location where I originally signed, except to the extent that others have already acted in reliance upon this Authorization. I understand that even if I revoke my Authorization, the health care providers that accessed my information may have included my health information in their records and are not required to remove my health information from their records.
- Information used or disclosed as a result of this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by applicable privacy laws.
- This Authorization will expire when the Hoag entity selected above and affiliates is no longer participating in Care Everywhere or upon my written revocation, whichever occurs first.
- I have a right to receive a copy of this Authorization.

Patient/Legal Representative Signature: _____ Date: _____ Time: _____

If signed by other than patient, indicate relationship: _____

Print Name (Legal Representative): _____

Staff Signature: _____ Date: _____ Time: _____

PATIENT LABEL