

## ILHIE's EHR Connect Opt-In Form

The Illinois Health Information Exchange's ("ILHIE's") EHR Connect ("EHR Connect") service is a statewide, secure electronic network that uses modern technology so that your doctors, specialists, hospitals, clinics, laboratories, pharmacies and health insurance plans ("EHR Connect Users") can share a summary of your electronic health information for authorized purposes like assisting with your treatment, payment and health care operations. To learn more about ILHIE's EHR Connect, visit [HYPERLINK to website]. Please read the "Notice to Patients Regarding the Illinois Health Information Exchange's EHR Connect" then, **if you decide you want to opt in to ILHIE's EHR Connect, complete and sign this form.**

### I Choose to Opt-In to ILHIE's EHR Connect.

By signing below, I confirm that I want to opt in to ILHIE's EHR Connect. I previously did not participate in ILHIE's EHR Connect, either because (1) I submitted an "ILHIE's EHR Connect Opt-Out Form," or (2) my health care provider removed me from ILHIE's EHR Connect participation because I have "specially protected health information" (defined below) which my health care provider cannot share through ILHIE's EHR Connect without my consent. By choosing to opt in, I understand that all my health information that is accessible through ILHIE's EHR Connect (including any specially protected health information) will be available through ILHIE's EHR Connect to other ILHIE EHR Connect Users for authorized purposes. I understand that I must sign this form for each of my providers who have removed me from participation in ILHIE's EHR Connect in order to make all my health information available through ILHIE's EHR Connect.

By signing below and giving my consent, I understand that all specially protected health information that my health care provider holds will be shared through ILHIE's EHR Connect, unless my health care provider is able to restrict the health care information that he or she provides through ILHIE's EHR Connect.

Specially protected health information includes:

- certain alcohol and substance abuse treatment information,
- HIV testing and information,
- genetic testing and information,
- child abuse and neglect reports and records,
- sexual assault evidence and information,
- mandatory public health reports that identify me,
- veteran's homes resident records, and
- any other health information that requires my consent in order to be disclosed under Federal or State law.

Please Note: Agreeing to participate in ILHIE's EHR Connect does not mean that you have elected to participate in any other health information exchanges.

### Complete all of the following information:

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Previous Last Name: \_\_\_\_\_ Birth Date: (Ex. 01/01/1990) \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number 1: \_\_\_\_\_ Phone Number 2: \_\_\_\_\_

Email Address: \_\_\_\_\_ Last Four (4) Digits of Social Security Number (if available): \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If the patient is 12 years of age or over, the patient must sign the form. If the patient is 11 years of age or under, the patient's parent or legal guardian must sign the form. (Check, if applicable:  Parent  Legal Guardian.)

**Give this completed form to your health care provider.** Please note that, if your provider has specially protected health information about you in his or her possession, you will have to consent to share the specially protected health information through ILHIE's EHR Connect unless your health care provider is able to restrict the health care information that he or she provides through ILHIE's EHR Connect. Your health care provider will give you a consent form to share any specially protected health information. Questions? Contact [ILHIE.Privacy@illinois.gov](mailto:ILHIE.Privacy@illinois.gov)