NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

If you have any questions about this notice, please contact:

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HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

Health Information Exchange (HIE):

Dr. Carl Wagreich may make your individual health information available to a sponsored Health Information Exchange (HIE) and to a regional and/or National Health Information Exchange including, but not limited to, the National Health Information Network (NHIN). A HIE is the electronic transmission of healthcare-related information among facilities, health information organizations and government agencies which provides a mechanism for healthcare providers to share information electronically, with the common goal to improve healthcare delivery and the quality of care for our patients while protecting the privacy and security of Health Information. **For example**, we will be sharing your health information with our Accountable Care Organization (ACO). If you received treatment in our office; and your physician, who may be a participant in our ACO, would be able to access and review the treatment you received at the office during your physician office visit. Your physician will have access to the most current information about your care and treatment.

Accountable Care Organizations (ACO) are organizations formed by groups of doctors and health care providers that have agreed to work together to improve care coordination and providing care that is appropriate, safe and timely. An ACO must meet quality standards set by the Centers of Medicare Medicaid Services (CMS) relating to care coordination and patient safety, appropriate use of preventative health services, improved care for at-risk populations, and patient and caregiver experience of care.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of information about how we may use and disclose your protected health information. We encourage you to read it in full. It includes but is not limited to following provisions:

Health Information Exchange (HIE) - we may make your individual health information available to a sponsored Health Information Exchange (HIE) and to a regional and/or National Health Information Exchange.

I have been made aware of the above disclosures and understand that complete details are available in the Notice of Privacy Practices I was given. _____ Initials

Name of Patient/Legal Representative *(please print)* Date

Signature of Patient/Legal Representative If Legal Representative, please give relationship

Torrance Memorial Health Information Exchange Opt-Out Form

Torrance Memorial Health System Health Information Exchanges (HIE's)
Opt-Out Form

_____ _____
Name Date of Birth

_____
Address

_____ _____ _____
City State Zip code

_____ _____
Contact Phone Email address

The Torrance Memorial Health System utilizes Health Information Exchanges (HIE's). These are secure, electronic ways of sharing health information among participating doctor's offices and other health care providers. An HIE is important because sharing health information improves care. The exchanges utilized by Torrance Memorial Health System helps your participating providers share information in a timely manner and more effectively coordinate your care.

After considering my option of participating in the Torrance Memorial Health System's HIE's, I have decided to OPT-OUT and NOT participate in these HIE's. By choosing to OPT- OUT of the Torrance Memorial Health System's HIE's, I hereby acknowledge and agree as follows:

1. Opting out of the HIE's may delay access to important medical information.
2. My health information will not be shared among health care providers through the HIE's. Instead, my providers will continue to share my information via previously established methods, such as phone, fax, or mail.
3. My health information will NOT be shared with other HIE's in which Torrance Memorial Health System may participate.
4. Any information that is shared before I submit this HIE Opt-Out form may remain with providers who accessed information before the Opt-Out went into effect.
5. My HIE Opt-Out selection will remain in effect unless I change it in writing; and
6. This request can take up to 3-5 business days to take effect.
7. A separate form must be completed by each family member wishing to Opt-Out.

If this form is signed by someone other than the person named above, the person signing the form hereby certifies that he/she is acting as: (Check One) ___Parent ___Legal Guardian ___Other (Specify Relationship)_____for the person named above.

_____ _____ _____
Printed Name Signature Date