Consent for Access to Health Information by Providers

By signing this form, I give my permission Practice to send and receive my health information for the following treatment purposes:

- Data Sharing for Treatment Purpose: Practice has the ability to share your/your child's health information with your other providers through electronic data sharing programs (e.g., Epic Care Everywhere, Carequality, and EpicCare) or other similar data sharing programs. I give permission to Practice to share my health information with my other providers at other locations. This may include Highly Confidential Information, for the purposes of care, treatment and care coordination. If I prefer not to share my data in this way, I do not have to sign this form but this will mean that my data cannot be shared by these date sharing programs automatically, *including in an emergency situation.*
- Illinois Immunization Registry: Practice may disclose information concerning your Immunization records to the Illinois Department of Public Health ("IDPH") for inclusion in a centralized database of children's immunization records. Such information may be used by the IDPH, public vaccine providers, community health centers, the Center for Disease Control and Prevention, or any other person or entity providing immunization services or approved by the IDPH as needed to know your health or immunization status. Such information may be used by these recipients to: provide immunization services to you; monitor your immunization status; promote adherence to recommend immunization schedules; assist in the preparation of vaccination documentation required by your school; prepare statistical reports on immunization status of groups of patients in which neither you nor any other patient may be individually identified; and otherwise monitor and promote your health and the health of children in Illinois generally. If I prefer not to share my data in this way, I do not have to sign this form but this will mean that my data cannot be shared by these data sharing programs automatically,
  Including in an emergency situation.

  Revocation: You may revoke your authorization to disclosure information by notifying Practice of such revocation in writing. Revocation will not affect any disclosures already made *prior to* Notice of revocation to Practice.

Expiration: Your authorization is valid for one (1) year

Patient Name (PLEASE PRINT FIRST & LAST NAME):_____

Parent/Legal Guardian SIGNATURE: _____

Relationship to Patient: _____

Date: _____