HEALTH INFORMATION EXCHANGE (HIE)

CHANGE OF SHARING STATUS

Please use this form only if you wish to change your current status to allow Health Information Exchange to share your information with clinicians who have a test or treatment relationship with you.

As of _____ (date), I will be changing my HIE status:

☐ **Opt-Out**: I do not agree to have my personal health information shared in the Health Information Exchange (HIE)

☐ **Opt-In**: I now agree to have my personal health information shared in the Health Information Exchange (HIE). This may include information from before today's date.

_____ Signature of Client*		_____ Date
_____ Signature of Responsible Adult**	_____ Relationship to Client	_____ Date
_____ Signature of Witness ***	_____ Language	_____ Date

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.	**Name:** **IS#:** **Agency:** **Provider #:** **Los Angeles County – Department of Mental Health**