MH 728
REVISED 7/31/26

Los Angeles County Department of Mental Health
Health Information Exchange (HIE) Change of Sharing Status

Change of HIE Sharing Status

Please use this form **only** if you wish to **change** your current status to allow or restrict Health Information Exchange (HIE) sharing with clinicians who have a test or treatment relationship with you.

Effective Date of Status Change: _____ (MM/DD/YYYY)

Select one of the following options below:

☐ **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 relevant health information recorded prior to today's date.

Acknowledgements and Signatures

Signature of Client*:	Name of Client:	Date:
Signature of Responsible Adult**:	Relationship to Client:	Date:
Signature of Witness / Interpreter***:	Language Interpreted:	Date:

* Minor Client: A minor client receiving services under his/her own signature must have the signed Consent of Minor form on file in the clinical record.
** Responsible Adult: Guardian, Conservator, or Parent of minor when required by law.
*** Witness/Interpreter: Person who witnessed the signing of the form (staff or other) OR interpreted this form into another language for the client.

Name: _____ **ID#:** _____

Agency: _____ **Provider #:** _____

Los Angeles County – Department of Mental Health