EXCHANGE OF HEALTH INFORMATION
Request to Change Consent

I understand that my treating providers have access to my medical records through the CliniSync Health Information Exchange.

If you DO NOT want to have your records shared, please mark the box below.

☐ **I DO NOT want to have my records shared on a Health Information Exchange.** I understand that my test results and medical information will not be accessible to healthcare providers (including emergency room physicians) through CliniSync. I understand that I may choose to participate in CliniSync again at any time.

If you previously did not want to have your records shared and NOW WANT them shared, please mark the box below.

☐ **I CONSENT to have my records shared through the Health Information Exchange.** I have read the informational form. I have had a chance to ask questions. I am satisfied with the answers.

First Name: _____ Middle Name: _____

Last Name: _____

Previous Last Name: _____ Date of Birth: _____

Gender: ☐ Male ☐ Female

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (_____)_____OR Cell: (_____)_____

Email Address: _____

Last Four Digits of Social Security Number: _____

Patient Signature: X _____ Date: _____

(If under the age of 18, signature of parent or legal guardian)_____

You may return this form in person or mail to your provider's Orthopedic ONE office. The Change in Consent will be completed by Orthopedic ONE.

OR you can have this form notarized or witnessed by an Orthopedic One staff member (below) and mail it to: Att: CONSENT STATUS, Ohio Health Information Partnership, 3455 Mill Run Drive, Suite 315, Hilliard, OH 43026.

IF mailing directly to the Ohio Health Information Partnership, this Section must be completed by a Notary Public or Medical Office:

I witnessed the above named individual sign this document and the individual is personally known to me or provided me with valid picture identification on this day ____ of _____, 20_____.

Notary or Medical Office Staff Print Name: _____

Phone Number: _____

Notary or Medical Office Staff Signature: X _____