EXCHANGE OF HEALTH INFORMATION
Request to Change Consent

I understand that my treating providers have access to my medical records through Health Information Exchange(s) Orthopedic One participates in.

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 the Health Information Exchange(s).** I understand that my test results and medical information will not be accessible to healthcare providers (including emergency room physicians) through Health Information Exchange(s). I understand that I may choose to participate in the Health Information Exchange(s) 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 previously opted out of sharing records on the Health Information Exchange(s) and NOW CONSENT to have my records shared through the Health Information Exchange(s).**

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:
Orthopedic One, Inc., ATTN: HIE Consent Status, 170 Taylor Station Rd., Columbus, OH 43213
Notary or Medical Office Staff Signature: X _____