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 my records on the Health Information Exchange(s) and I 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: Compliance Manager, 340 Polaris Parkway, Westerville, OH 43082
Notary or Medical Office Staff Signature: X ______________________________