CONSENT FORM

FOR ePRESCRIBE PROGRAM

ePrescribing is way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:

- **Formulary and benefit transactions** - Gives the health care provider information about which drugs are covered by your drug benefit plan.
- **Fill status notification** - Allows the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.
- **Medication history transactions** - Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

  The medication history information would include medications prescribed by your health care provider at Burlington Pediatrics LLC as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic diseases, and HIV/AIDS. **As part of this Consent Form, you specifically consent to the release of medications related to sensitive health information.**

Consent

By signing this consent form you are agreeing that your provider at Burlington Pediatrics LLC. may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.
This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to Burlington Pediatrics LLC to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Burlington Pediatrics LLC Notice of Privacy Practices. By signing below I am giving acknowledgement that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

_____ _____

Print Patient Name Date

_____ _____

Patient DOB Relationship to Patient

_____

Signature of Patient or Guardian

The Health Information Exchange of Winchester Hospital and The Highland Healthcare Associates Independent Physicians Association (IPA)

PATIENT AUTHORIZATION FORM

In this Authorization Form, you can choose whether to allow doctors, hospitals, and other health care providers who are involved in your medical care, health care providers who are covering for your providers, and the staff of these health care providers to share and obtain access to your medical records through eLINC. eLINC is a clinical patient information exchange system which gives your health care provider the ability to electronically share your health information with other health care providers involved in your care or the coordination of your care. This can help collect the medical records you have in different places where you get health care and make them available electronically to the providers treating you. The Massachusetts Health Information Highway (Mass HIway) is a collaboration between the Massachusetts Executive Office of Health and Human Services (EOHHS) and MeHI to deploy a secure statewide health information exchange. The Mass HIway enables the electronic movement of health related information among diverse organizations, such as doctors' offices, hospitals, laboratories, pharmacies, skilled nursing facilities and health plans. The HIway facilitates the exchange of clinical information among varied health care information systems, while maintaining the meaning of the information being exchanged, regardless of provider affiliation, location or differences in technology.

eLINC is an electronic health information exchange (HIE) managed and operated by Winchester Highland Management, a joint venture between Winchester Hospital and the Highland Healthcare Associates IPA, a physician organization of which your primary care physician may be a member. Through eLINC and/or Mass HIway, we share information about the health of our patients electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information exchange. It allows for faster and more efficient access to or sharing of health information contained on the eLINC HIE and/or through the Mass HIway. To learn more about the eLINC health information exchange, please ask your provider for the eLINC brochure or go to the website www.elinc.biz. To learn more about Mass HIway, please visit www.mehi.masstech.org/health-information-exchange-0/mass-hiway.

You may use this Authorization Form to decide whether or not to allow health care providers to send information about your care and treatment, and view and obtain access to your electronic health records. You can opt-in or opt-out of eLINC, and this form may be completed now or at a later date. If you choose to opt-in, you are giving your providers authorization to share and access your health information through both eLINC and Mass HIway. Once you opt-in with one provider who participates in eLINC or MA HIway, you will not need to opt-in again with additional providers who participate, and your information will be shared with any provider who is treating you. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to opt-in or opt-out may not be the basis for denial of health services.**

If you check the "OPT-IN" box below, you are consenting for hospital and/or practice providers and staff involved in your care and treatment to send information about your care and treatment, and view and obtain access to all of your electronically available medical records through eLINC and Mass HIway. This may include information created before and after the date of this Authorization Form. Your health records may include clinical encounters, insurance information, history of illnesses or injuries you have had (like diabetes or a broken bone), social history, family history, vital signs, advanced directives, test results (like X-rays or blood tests), medical procedures performed, immunizations received, any food or medication allergies you may have, plan of care from your health care providers, and lists of medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:

- Alcohol or drug use problems
- Birth control and abortion (family planning)
- Genetic (inherited) diseases or tests
- HIV/AIDS
- Mental health conditions
- Sexually transmitted diseases

If you check the "OPT-OUT" box below, you are saying "No hospital, doctor or other health care provider or provider staff may access or send my medical records through eLINC or Mass HIway for any purpose."

Please carefully read the information on the back of this form before making your decision.

Your Choices: You can fill out this form now or in the future. You have two choices. Please, select only one of the following.

☐ (OPT-IN) I AUTHORIZE hospital, health care providers, and hospital and provider staff in the Winchester community accessing and sharing all of my electronic health information through eLINC and/or Mass HIway in connection with providing me any health care services, and treatment, including emergency care.

☐ (OPT-OUT) I DO NOT AUTHORIZE hospital, health care providers, and hospital and provider staff in the Winchester community accessing and sharing my electronic health information through eLINC and/or Mass HIway for any purpose, *even in a medical emergency.*

NOTE: UNLESS YOU CHECK THE "OPT-OUT/I DO NOT AUTHORIZE" BOX, Massachusetts law allows the people treating you in an emergency to get access to your medical records, including records that are available through eLINC and/or Mass HIway.

I understand that my records are protected under federal and Massachusetts laws and regulations, and cannot be disclosed without my written authorization, except as otherwise specifically provided by law. I understand that I may revoke (cancel) this authorization at any time and I must do so in writing at the address below. I understand that any revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not be effective until it is actually received and processed. I understand that signing this authorization is voluntary. I understand that my medical records may be re-disclosed.

I understand that my medical records may contain information involving treatment for alcohol or drug abuse, and are also protected under the federal regulation 42 CFR Part 2, and any disclosure of my information to eLINC by my substance abuse treatment provider will include a notification that eLINC may not re-disclose my substance abuse treatment records without my authorization.

Further, information released with this authorization will not be given, sold, transferred or in any way disclosed to any other entity unless authorized by law, without my further authorization.

If I am enrolling my minor child, I understand and agree that when my child is between 12 and 18 years old that eLINC will not disclose substance abuse or family planning information to me, or if my child is between 16 and 18 eLINC will not disclose mental and/or behavioral health treatment to me. I also understand and agree that if my child is between 12 and 18 years old, or if my child is or was married, is a member of the armed services, is living apart from me and is financially independent, or reasonably believes herself to be pregnant (but not in regards to an abortion or sterilization), is a parent, or reasonably believes he or she has come into contact with a disease defined as a danger to public health (i.e. sexually transmitted disease), or has consented to emergency treatment eLINC will not disclose such information to me.

Effective Period. This Authorization Form will remain in effect until the day you withdraw your authorization or until such time as eLINC ceases operation, whichever is sooner.

Print Name of Patient	Patient Date of Birth
Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)