Speare Memorial Hospital - *A Critical Access Hospital*
16 Hospital Road
Plymouth, NH 03264

Last name _____ First name _____ M.I. ___

Date of Birth _____ Primary Care Provider _____

Patient Consent for Electronic Medical Record Access

With your permission, providers and staff members of Speare Memorial Hospital will be given access to all available electronic records documenting any medical care you receive or have received at Mid-State Health Center. Additionally, the providers and staff members of Speare Memorial Hospital will be expected to share with Mid-State Health Center all clinical information about the care they provide to you. You are being asked to agree to this disclosure, exchange, and use of clinical information because your providers believe that timely access to such information will improve the quality of your care.

Records that exist now and any that may be created in the future will be shared. The shared clinical information may include items such as lab test results, operative reports, office visit notes, x-ray reports, hospital discharge summaries and other clinical information relating to you and the care you receive. **This confidential information may also include some or all of the following: diagnostic or treatment information relating to mental health or psychiatric conditions; Information relating to referrals for, or the diagnosis or treatment of, drug or alcohol abuse; genetic testing information or results; information relating to being a victim of, or counseling about, domestic abuse, neglect, or violence; and/or HIV/AIDS test results or treatment.**

The shared information will be used only for the purposes of facilitating your medical treatment, payment for that treatment, or certain limited health care operations uses permitted under HIPAA – the Federal Privacy Rule.

Mid-State Health Center and Speare Memorial Hospital are committed to respecting and protecting the confidentiality of your clinical information and have policies and procedures in place to protect your health information. Access to your electronic medical records is tracked and this access may be audited to assure that it is appropriate. (For further information on Mid-State Health Center's patient privacy policies go to www.midstatehealth.org.)

By signing below you are indicating that you are aware of this arrangement for sharing electronic access to protected health information between Mid-State Health Center and Speare Memorial Hospital and give consent for such disclosure, exchange, and use of your protected health information. This consent is effective beginning on the date below and will continue until revoked by you. To revoke this consent you must notify Information Management at Mid-State Health Center or Speare Memorial Hospital. You will still receive medical treatment and services even if you decide not to permit the sharing of electronic access to your protected health information.

_____ _____ _____
Patient's Signature (printed if pt unable to sign) Contact Phone Number Date

_____ _____
Signature of Personal Representative's Relationship to Patient

_____ _____
MSHC Witness Signature Date