HIE Opt-In Consent Form

This form is to be used by patients who want to participate in the Health Information Exchange (HIE)

The Wyoming Frontier Health Information Exchange (WYFI) allows you to permit your health information to be shared by participating medical groups, hospitals, labs, radiology centers, and other health care providers through secure, electronic means. The purpose of the WYFI is to give each of your participating providers the benefit of having access to all of your health information that is maintained by the participating providers when providing healthcare to you.

Your participation in the WYFI is voluntary and your receipt of treatment or health plan coverage for treatment will not be conditioned on whether or not you sign this form. You should be aware that depending on your providers' technical capabilities, even if you do not sign this form, your health information may still be disclosed to the WYFI, but the WYFI will not permit it to be viewed, except as described above related to hospital health information.

By signing this form, I hereby ACKNOWLEDGE and AGREE as follows:

1. My health care providers that participate in the WYFI may disclose my health information to the WYFI and my health information may be shared with all health care provider participants of the WYFI that are involved in my care. The WYFI may also share my health information with members of other health information exchanges to which the WYFI connects who are involved in my care.
2. My health information that will be shared through the WYFI will include health information from both before and after today's date and may include information related to treatment I received from any provider who is connected, either directly or indirectly, to the WYFI, including out-of-state providers. For example, if I have received care at a Banner Health System facility in Arizona, my information related to that care will be included in the WYFI, even if I reside or sign this form in Arizona and even if I previously opted-out of the WYFI by signing the proper opt-out form.
3. My health information that will be shared through the WYFI includes information about my diagnoses, test results (like x-rays or laboratory), and medications that have been prescribed to me.
4. My health information that is made available to the WYFI may be used by WYFI participants for treatment purposes. The WYFI may further use my health information and make it available to other health information exchanges and their participants, for treatment, payment, and health care operations activities; however, such disclosures by the WYFI to another health information exchange will only be permitted in accordance with applicable law and information that is disclosed will not include HIV test results, mental/behavioral health records, and genetic/hereditary test results.
5. Health care providers who receive health information about me through the WYFI may copy or include my health information into their own medical records when caring for me. If I cancel this consent, such cancellation will have no effect on the health information such providers already accessed and copied.
6. I understand that this consent will remain in effect until I cancel it. I may cancel this consent by completing the WYFI "Revocation of HIE Opt-In Request Form" and submitting the completed form to the address provided on the form or to Admissions, Registration or Front Office staff at a WYFI

facility.

7. It may take between 2 - 5 business days after receipt to process my consent and for the WYFI to make my information available for sharing through the WYFI.
8. I have a right to ask for a copy of this form after I sign it.

Patient's Name: Last*	First*	Middle Initial
Previous Name or Nicknames:	Patient's Date of Birth:*	Primary Phone Number:* ( ) -
Email:	Sex (M/F):	Secondary Phone Number:* ( ) -
Postal Address:*	City:*	State:* Zip:*

*required information

_____ _____

Signature of Patient (or Legal Representative) **Date Signed**

If under 18 years, signature of Patient or Guardian

_____ _____ _____

Legal Representative Name* Legal Representative Relationship to Patient* Legal Representative Phone

*Please fill out and return form to **Wyoming Frontier Information**:

Address:
Wyoming Department of Health
Office of Healthcare Financing
Attention: Ruth Jo Friess
122 W. 25th Street, 4th Floor
Cheyenne, WY 82002
(307) 777-5414

Contact Us:
Ruth Jo Friess, Wyoming Frontier Information ruth.jo.friess@wyo.gov
Andrea Bailey, Wyoming Frontier Information andrea.bailey@wyo.gov