Consent to Share My Health Information
Jackson Hinds Comprehensive Health Center Electronic Health Exchange (eEHX)/Kansas Health Information Network (KONZA)

What is Jackson Hinds Comprehensive Health Center eEHX/Kansas Health Information Network (KONZA)?

The Jackson Hinds Comprehensive Health Center Electronic Health Exchange (eEHX)/Kansas Health Information Network (KONZA) [eEHX/KONZA] is designed to improve your health care and make your office visits easier and more convenient.

This authorization will allow all of your doctors and other authorized personnel, participating in this eEHX/KONZA, to appropriately access and securely share your vital medical information electronically, thus improving the speed, quality, and safety of your healthcare. This digital format of health information helps to ensure every person participating in your care, is working from the same information. Additionally, this helps to improve your health outcome.

If you consent to share your information through eEHX/KONZA, you are giving your permission for authorized personnel to see and obtain access to your electronic health records. **Your choice to give or deny consent will not be the basis for denial for health services. However, your health information will not be available to other providers participating in the eEHX/KONZA for your medical treatment.**

If you check the "I GIVE CONSENT" box below, you are saying "Yes, members of the eEHX/KONZA may see and get access to all of my health information through the eEHX/KONZA."

If you check the "I DENY CONSENT" box below, you are saying "No, members of the eEHX/KONZA may not be given access to my health information through the eEHX/KONZA for any purpose."

Please carefully read the "Details About Your Health Information" form before making your decision.

Your Consent Choices: You can fill out this form now or in the future. You have two Choices:

❑ **YES, I GIVE CONSENT,** for my doctors to enroll me in the eEHX/KONZA and for the members of the eEHX/KONZA to access ALL of my health information as set forth in this Consent Form.

❑ **NO, I DENY CONSENT,** for my doctors to enroll me in the eEHX/KONZA and for the members of the eEHX/KONZA to access ALL of my health information as set forth in this Consent Form.

Printed Name of Patient:	
Signature of Patient/Guardian/Representative:	**Date:**

I, _____**,** do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis:

Relationship to Patient:	**Date:**