Epic CareEverywhere

You are receiving this notice because your health care provider participates in an electronic information service offered by HonorHealth. This service does not cost you anything and can help your doctor and health care providers, including those outside of HonorHealth, to better coordinate your care by securely sharing your health information through a system called Epic CareEverywhere.

If you would like your doctor and other health care providers, including providers outside of HonorHealth, to share your health information electronically and securely to better coordinate your care, YOU DO NOT NEED TO DO ANYTHING.

Your information will automatically be shared with your health care providers unless you decide to "Opt-Out."

What does it mean to securely share information and how can it help you get better care?
In a paper-based medical system, your medical tests or lab results are either mailed or faxed to your primary care doctor. Paper or faxed records could potentially be lost or not arrive in time for your doctor visit. With electronic information sharing, your doctors and other health providers can securely share your health information with each other in a secure and timely manner. This ensures that your information is the same across different providers and saves you time in giving the same information to numerous health care providers.

What medical information is available to be securely shared?
Health care providers will be able to share several types of health information about you, including but not limited to:

- Admission and discharge information from hospitals that use CareEverywhere
- Medical history
- Medicines you take
- Allergies – including allergies to medicines

Allergies – including allergies to medicines
Doctor visit information
Lab test results and radiology reports

Who can view your medical information electronically?
Your medical information will be available to doctors, nurses, and other care providers in order to provide and coordinate your care. This includes health care providers who are not part of HonorHealth. Your health insurer may also view your information to help coordinate or manage your care.

How is your medical information protected?
HonorHealth is required to follow federal law – the Health Insurance Portability and Accountability Act or "HIPAA" – to protect your private health information. Individuals with access to your medical information are provided with a secure username and password and are trained on patient privacy rules before they can access your information. Ongoing monitoring is conducted to ensure appropriate access to your medical information is made.

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You have the right under article 27, section 2 of the Arizona Constitution to keep your medical information from being shared electronically through CareEverywhere. Specifically, you may:

1. "Opt-Out" of having your information shared with other CareEverywhere users. To Opt-Out, you must complete the CareEverywhere Opt -Out form below and submit to Health Information Management (HIM) at the address below.

   HonorHealth Health Information Management
   2500 W. Utopia
   Phoenix, AZ 85027

   Phone Number: 480-882-4040
   Fax Number: 480-882-5841

2. Change your mind at any time. If you say no today, you can change your mind at any time. If you do nothing today and allow your health records to be shared, you may "Opt-Out" in the future.

CareEverywhere Opt-Out Form

Please check the box next to your choice regarding the secure sharing of your health information among your health care providers, including those outside of HonorHealth. Be sure to sign the form at the end.

☐ **Choice 1:** I do not agree to have my medical information securely shared among my health care providers. I understand and accept the risks associated with denying any access by anyone under any circumstances including medical emergencies.

☐ **Choice 2:** I want to change an earlier decision not to have my medical information shared among health care providers. I now agree to have my medical records securely shared. This may include health information gathered prior to the date I signed this form.

Patient Name (print): ____ Date of Birth: ____________

Signature: _______________________________________ Date: ____/____/____

Complete this section only if a person other than the patient signed this form.

Do you have authority to make health care decisions on behalf of the patient?

Yes ☐ No ☐

What is your relationship to the patient? ________________________________