HEALTH INFORMATION EXCHANGE CONSENT

Family Care Associates of Blair County DBA Quantum HealthCare Services LLC
James Frommer DO
125 Carson Valley Road
Duncansville, PA 16635
Phone: (582) 465-7008

Patient Name (Print): _____ DOB: _____

I, the above-named patient, hereby authorize the electronic exchange of my protected health information (PHI) through the Health Information Exchange (HIE) network.

I understand that the purpose of the HIE is to improve the quality, safety, and efficiency of my healthcare by allowing my healthcare providers to securely access and share my PHI with each other. I understand that the information exchanged may include, but is not limited to, the following:

- Medical history and diagnoses
- Medications and allergies
- Lab and test results
- Imaging reports
- Discharge summaries
- Treatment plans and progress notes

I understand that my PHI will only be exchanged between healthcare providers who are involved in my care and who have a legitimate need for the information. I understand that my PHI will be protected by state and federal laws governing the privacy and security of health information.

I have the right to revoke this consent at any time by notifying the HIE in writing. I understand that if I revoke this consent, it will not affect any actions taken prior to the revocation.

I have received a copy of the Notice of Privacy Practices, which explains in detail how my PHI may be used and disclosed, and I understand my rights and responsibilities with respect to my PHI.

By signing below, I acknowledge that I have read this consent form, understand its contents, and agree to the electronic exchange of my PHI through the HIE network.

Patient Signature: _____ Date: _____

Representative Name: _____ Relationship: _____

Witness Signature: _____ Date: _____