Department of Veterans Affairs

REQUEST FOR AND PERMISSION TO PARTICIPATE IN SHARING PROTECTED HEALTH INFORMATION THROUGH HEALTH INFORMATION EXCHANGES

By completing this form, you are authorizing VA to share your protected health information through VA health information exchanges (HIE). HIE allows health care professionals and patients to access and securely share a patient's medical information electronically. HIE enables VA to electronically share patient information with community providers and other HIE partners. If you are completing this form, you had previously chosen to opt-out of HIE. By completing this form, you are cancelling your previous opt-out request. Opt-in means that all of your health information can be shared through HIE. Opt-out means that none of your health information can be shared through HIE except in a life-threatening medical emergency. By providing the information requested on this form, you will be opted in to the electronic exchange of health information for treatment purposes. Your disclosure of the information requested on this form is voluntary. A decision to complete the form will not have any effect on any benefits to which you may otherwise be entitled. Because VA uses the Social Security Number (SSN) to electronically locate patient records, you need to provide your complete and accurate SSN in order for us to carry out your request to participate.

PRIVACY STATEMENT: Your disclosure of the personal information requested on this form is voluntary. However, if the information containing the Social Security Number (SSN) (the SSN will be used to locate records) is not furnished completely and accurately, the Veterans Health Administration (VHA) will be unable to comply with your request. By completing this form, you will be opted in to the electronic exchange of health information for treatment purposes. Failure to furnish the personal information will not have any effect on any other benefits to which you may be entitled; however, you will not be opted in to health information exchange. Consistent with the VA Notice of Privacy Practices, VA may also use the information on this form for purposes other than your treatment as authorized or required by law. The information collected on this form is part of a Privacy Act system of records, "Virtual Lifetime Electronic Record (VLER)-VA", 168VA10P2. The information requested on this form is solicited under Title 38, U.S.C. 501.

VETERAN'S FULL NAME:

LAST *(Print)*	FIRST	MIDDLE	9-DIGIT SSN

PARTICIPATION REQUEST:

By signing this form, I request and authorize VA to release my protected health information through health information exchanges for community providers and other HIE partners to provide me treatment. By completing this form, I am cancelling the opt-out request I previously submitted. I understand that the sharing of my electronic health information through HIE will no longer be restricted. I also understand that consistent with the VA Notice of Privacy Practices, VA may also use the information on this form for purposes other than my treatment as authorized or required by law.

I certify that I am making this request freely, voluntarily, and without coercion. My opt-in request will be in effect unless and until I opt-out in writing on VA Form 10-10164.

If you decide that you would like to be opted out of HIE, you will need to contact the Release of Information Office at the VA Medical Center where you receive treatment or call the Health Eligibility Center (HEC) Call Center at 1-877-771-VLER (8537).

SIGNATURE:

_____ _____

Signature of Patient Date

_____ _____

Signature of Legal Representative *(if applicable)* Date

To Sign for Patient *(Attach authority to sign: Health Care Power of Attorney or Legal Guardian)*

_____

Name of Legal Representative *(please print)*