



4665 Business Center Drive
Fairfield, California 94534

Health Information Exchange (HIE) Member Opt Out/Opt In Form

Partnership HealthPlan of California (PHC) stores your Protected Health Information (PHI) electronically. Your healthcare providers may share your vital health information to improve the speed, quality, safety and reduce cost of your care. PHC calls this method of sharing your records Health Information Exchange (HIE).

Your PHI is your medical information, like medical notes, labs, X-rays, prescriptions, and payment information. **If you don't want to share your PHI, you must complete the HIE Member Opt Out/Opt In Form for PHI.** Then sign and send the form to us by either mail, fax, or walk-in.

If you do not opt out of sharing your PHI, you agree to allow PHC to share your information. You may always opt out at a later date and no new data will be shared by PHC. However, data that has already been shared will not be taken back.

Another type of PHI is **Sensitive** Protected Health Information (PHI) like mental health diagnosis and treatment; drug or alcohol abuse diagnosis or treatment; sexually transmitted diseases; birth control; genetic test results; and HIV test results. We will NOT share your sensitive PHI without your written approval. **If you want to share your sensitive PHI, you must complete the HIE Member Opt Out/Opt In Form for Sensitive PHI.** Then sign and send the form to us by either mail, fax, or walk-in.

You will not be denied treatment if you change your choices of sharing your PHI. Your Medi-Cal benefits will not be affected.

If you need help reading this letter or have any questions, please call us by calling **(800) 863-4155**. We are available to help you Monday – Friday, 8 a.m. – 5 p.m. TTY Users: Call the California Relay Service at **(800) 735-2929** or call **711**. Don't forget to visit our website at www.partnershiphp.org.



Protected Health Information (PHI)

(i.e., doctors' medical notes, labs, X-rays, prescriptions, and payment information)

I request to **OPT OUT** of sharing my Protected Health Information (PHI) with Health Information Exchanges (HIEs) that PHC is a part of.

I agree to **OPT IN** to share my Protected Health Information (PHI) with PHC. I understand that my past and present health information will now be visible to all of my health care providers, HIE Networks, and PHC. I also acknowledge that PHC can share my PHI throughout the Health Information Exchanges (HIEs) they partner with.

Sensitive Protected Health Information (PHI)

(i.e., mental health diagnosis and treatment; drug or alcohol abuse diagnosis or treatment; sexually transmitted diseases; birth control; genetic test results; and HIV test results.)

I agree to **OPT IN** to share my Sensitive Protected Health Information (PHI) with PHC. I understand that my past and present health information will now be visible to all of my health care providers, HIE Networks, and PHC. I also acknowledge that PHC can now share my Sensitive PHI throughout the Health Information Exchanges (HIEs) they partner with.

I request to **OPT OUT** of sharing my Sensitive Protected Health Information (PHI) with Health Information Exchanges (HIEs) that PHC is a part of.

Member Name:	Date of Birth:
Or Personal Representative's Name:	
What legal authority do you have to act on behalf of the member	
<input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Executor/Conservator <input type="checkbox"/> Other	
Signature:	
Member ID:	
Date:	

Mail complete form to:
 Partnership HealthPlan of California
 c/o Member Services Department
 4665 Business Center Drive
 Fairfield, CA 94534

Or fax completed form to:
 Fax: (707) 863-4415