

Health Information Exchange

Partnership HealthPlan of California keeps your protected health information (PHI) electronically. Your health care providers may share your health information to improve the speed, quality, safety, and cost of your care. This way of sharing your records is called Health Information Exchange (HIE).

Your PHI includes medical notes, labs, X-rays, prescriptions, and payment information. If you do not want to share your PHI, you must fill out the form on the next page. The form must be signed and returned to Partnership by mail, fax, or in person.

If you do not fill out this form, you agree to allow Partnership to share some of your PHI with health information exchange partners. You may always choose not to share your PHI at a later date and no new data will be shared by Partnership. Data that has already been shared will not be taken back.

PHI relating to sensitive services will **NOT** be shared without your written approval. PHI related to sensitive services includes:

- Mental or behavioral health diagnosis and treatment
- Substance use disorder diagnosis or treatment
- Sexually transmitted infections
- Sexual and reproductive health diagnosis and treatment
- Birth control/contraception
- Abortion or abortion-related treatment
- Genetic test results
- HIV test results
- Gender-affirming care related treatment
- Intimate partner violence diagnosis and treatment

If you want to share your PHI relating to sensitive services, you must complete the form on the next page. The form must be signed and returned to Partnership by mail, fax, or in person.

This notice does not change your Partnership benefits or keep you from getting the care you need.

If you need help or have any questions, please call us at **(800) 863-4155**, Monday – Friday, 8 a.m. – 5 p.m. TTY users can call the California Relay Service at **(800) 735-2929** or **711**.

To learn more, visit our website at PartnershipHP.org.



Health Information Exchange Member Form

Protected Health Information (PHI) includes past and present information related to providers' medical notes, labs, X-rays, prescriptions, and payment information. Please choose from the options below:

- I do not want to share my PHI with health information exchange partners.**

PHI related to sensitive services includes information related to mental or behavioral health diagnosis and treatment, substance use disorder diagnosis or treatment, sexually transmitted infections, birth control/contraception, sexual and reproductive health care diagnosis and treatment, abortion or abortion related treatment, genetic test results, HIV test results, gender affirming care, and intimate partner violence diagnosis and treatment.

- I agree** to share my PHI related to sensitive services with Partnership and allow Partnership to share such PHI with health information exchange partners. I understand that my past and present health information related to sensitive services will now be shared with all of my health care providers, health information exchange partners, and Partnership.
- I do **not** want to share my PHI related to sensitive services with health information exchange partners.

Member Name:	Date of Birth:
Or Authorized Representative's Name:	
What legal authority do you have to represent 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 completed form to:

Partnership HealthPlan of California
Attn: Member Services
4665 Business Center Drive
Fairfield, CA 94534

You can also fax the completed form to (707) 863-4415.