Beth Israel Deaconess HealthCare®

SHARING PATIENT HEALTH INFORMATION WITH FAMILY AND FRIENDS

Why complete this form? By completing this form you are allowing Beth Israel Deaconess HealthCare (BIDHC) to share your health information with the person you list below. Your health information may include general health information such as appointment times and medications as well as protected or privileged information.

Privileged or Specifically Protected Information may include the following:

- Alcohol or drug abuse treatment
- Domestic violence victim's counseling
- Sexual assault victim's counseling
- Communication between patient and social worker
- Mental health information
- HIV / AIDS diagnosis and/or treatment
- Results of genetic testing
- Sexually transmitted diseases

Who should complete this form? BIDHC patients over the age of 18, legal representatives of other adults (e.g., health care proxy, legal guardianship), emancipated minors, or parents/legal guardians of patients under the age of 13.

Ways you can allow BIDHC to share your health information:

- **Electronically** through the patient portal, MySite. There are two access designations.
  - Full Access – means the person you list will have access to all information in your MySite account that you have access to.
  - Billing Only Access – means the person you list will have access to billing information only. Billing information may contain limited information about your visit such as tests performed.
- **Verbally**. BIDHC staff will speak with your family member or friend about your health information for purposes of ongoing care. We will limit the information we share with your family member or friend to their involvement in your care to the fullest extent possible. Allowing BIDHC to speak with your family member or friend about your health information does not give them access to your health information in paper or electronic format unless you specifically allow us to share your health information that way.

	Permission Type		
Information available (examples):	**Verbal**	**MySite Full Access**	**MySite Billing Only Access**
View lab results, allergies, immunizations, medications on MySite		✓	
Request appointments and/or prescription renewals	✓	✓	
Talk to your doctor about health concerns	✓	✓	
View and pay your bills on MySite		✓	✓

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Patients Under the Age of 18:
Parents and legal guardians of patients under the age of 18 do not have to grant verbal permission to themselves or other parents/legal guardians. Staff will talk to you about the patient's care with certain limitations. Please read below for age-specific exceptions.

Patients between the ages of 0-12:

A parent or legal guardian may request access to a minor patient's MySite account by completing this form. Please remember that if you contact your child's doctor's office about your child through the patient portal, you must be logged in to your child's portal account.

Patients between the ages of 13 – 17:

Under Federal and State law, certain health information such as alcohol or drug abuse treatment, behavioral health, physical or sexual abuse, or family planning requires the minor patient's consent before sharing it with another person. This information will not be shared with you in any format without your child's permission. Your child can complete a separate form while at the doctor's office and designate their permission, including access to their MySite account.

Parent/Legal Guardian access to the patient's MySite account is shut-off or changed when:

- Patient or parent/guardian terminates access through MySite.
- Patient or parent/guardian submits a request in writing to the patient's primary care physician's office.
- Patient turns 13 years old.

What to tell your family member or friend:
Let the person you designate access to know that you have given permission to BIDHC to share your health information with them. Tell them:

- How BIDHC will communicate with them about your health information.
- If you have given them MySite access, they will receive an invitation email.
- If you do not want them to share your information with others.
- Your name and date of birth so we can verify your information.

Changing who we communicate with and/or how we communicate with others:
The permission you give BIDHC will remain in effect until you change or cancel it. You may cancel or change the permission you give to BIDHC at any time by doing one of the following:

- Logging into MySite and changing the permissions yourself.
- Filling out a new form.
- Send a written letter to your primary care physician's office requesting access to be shut-off. Any request for changes made in writing will not begin until your written request is received.

Questions?

- Contact your primary care physician's office or the BIDHC Compliance Office at (617) 754-0541.
- BIDHC Notice of Privacy Practices describes how medical information about patients may be used and disclosed and how patients can get this information. Ask your doctor's office how to obtain a copy.

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PERMISSION TO SHARE MY HEALTH INFORMATION WITH A FAMILY MEMBER OR FRIEND

To be completed by a patient over 18 years old or their legal representative, or parent/legal guardian of a patient under the age of 12

Patient Information

Full Name:_____ Date of Birth: _____

I allow BIDHC to share my health information with the person(s) listed below in the way I designate:

1. Full Name:_____ Date of Birth: _____

   Email: _____ Telephone: _____
   (Required only for MySite Access)

   Type of Access: ☐ Verbal ☐ MySite Full Access ☐ MySite Billing Only Access

2. Full Name:_____ Date of Birth: _____

   Email: _____ Telephone: _____
   (Required only for MySite Access)

   Type of Access: ☐ Verbal ☐ MySite Full Access ☐ MySite Billing Only Access

I understand and agree that:

- I had the opportunity to review this entire form and have my questions answered.
- I am voluntarily giving my permission to BIDHC to share my health information that may be protected or privileged with the person I list on this form.
- I do not need to sign this form to assure treatment.
- My permission does not expire until I change or cancel it. I can change or cancel the permission I am giving to BIDHC at any time by following instructions given in this form.
- Changes or cancellation to the permission I am giving to BIDHC does not apply to information already shared with the person I list on this form.
- It is my responsibility to tell the person receiving my information if they can share it with others. If they do share the information with others, those actions may not be protected under federal and/or state law.

Patient Signature: _____ **Date:** _____ **Time:**_____ **o a.m.** **o p.m.**

If signed by legal representative, print name: _____

Legal representative relationship to patient: _____
(A legal document showing legal authority must be on file or submitted with this form. You are responsible to notify BIDHC if your authority changes.)