SACVALLEY MEDSHARE	PROCEDURE: *Notification of Privacy Practices and Consent Procedure*	PROCEDURE NUMBER: *SVMS-PRO-002.001*
	Author: Elizabeth L Steffen John Helvey Dr. Kevin Dorsey-Tyler MD	Origination Date: 01/05/2015
	Revised By:	Revised Date:

Purpose:

To ensure that all participant's patients are aware of and understand how to opt-out of their data being available on the SacValley MedShare (SVMS) Health Information Exchange (HIE), to record those requests and to ensure they are flagged appropriately within the system.

Procedure:

1. **Participation agreement** shall include language that allows for patients of participants to opt-out of their information being available on the SVMS HIE.
2. **Participants** shall inform their patients of their participation in the HIE, and shall provide opportunity for their patients to indicate their wish to opt-out on an individual basis, or to revoke a prior decision to do so.
3. **Participants** should indicate that such decision is global in nature, and may prevent electronic access to critical health information by all healthcare providers, even in emergency.
4. **Participants** should effect local controls to prevent transfer of information from their electronic records associated with patients wishing to opt-out, but participants must also direct those patients that they must, in addition, inform SVMS of that decision.
5. **Participants** shall direct their patients wishing to opt-out to the SVMS website where a copy of the *SacValley MedShare Health Information Exchange Opt-Out Request* can be printed, filled out, and mailed to the address on the form (Attachment A, 2 page PDF form, SVMS-FORM-002 Opt-Out Form), or can print the form, collect it from their patient and forward to SVMS.
6. **Participants** shall direct their patients wishing to revoke their previous opt-out to the SVMS website where a copy of the *SacValley MedShare Health Information Exchange Opt Out Revocation Request Form* can be printed, filled out, and mailed to the address on the form (Attachment B, 2 page PDF form, SVMS-FORM-003 Opt-Out Revocation Form), or can print the form, collect it from their patient and forward to SVMS.
7. **SVMS** shall keep up both consent forms. They will be maintained in Microsoft ® Publisher ® and reviewed periodically for regulatory updates. PDF copies of the current version will be made available on the SVMS website.
8. **SVMS** shall keep all archived documents and processing logs on Box and as hard copies forwarded to the SVMS counterpart at the Hospital Council for at least the calendar year of 2015.
9. **SVMS** shall process all opt-out requests in a timely manner. For the purposes of this procedure, *timely manner* is defined as within 5 (five) business days after receipt of the signed patient request and follow these steps;
    a. SVMS administrator will receive the physical opt-out requests that were received via mail.
    b. SVMS administrator will process physical letters:
        i. Stamp the forms with "Received [Date: MM/DD/YYYY]",
        ii. Scan the letters to PDF format, and,
        iii. E-mail the PDF letters to SVMS Technical Project Lead.
        iv. One emailed, physical letters can be shredded.

c. SVMS Technical Project Lead will receive the letters via email.
   i. Letter is reviewed for completeness; *if letter is not completed, patient is contacted and a new form is requested if necessary. Note conversation on log* (Attachment C, Microsoft ® Excel ® workbook, SVMS-FORM-006) *and archive the PDF.*
   ii. Opt-Out is processed in the ICA system
   iii. Log is updated
   iv. PDF is uploaded/saved to Box; hard copies forwarded to Hospital Council (during the calendar year of 2015).

d. Process the response to the patient.
   i. Complete the form *Processed Opt-Out Response Form* (Attachment D, Microsoft® Publisher® form, SVMS-FORM-018).
   ii. Save completed form to Box.
   iii. Mail form to back to address on record (from original opt-out request).

Authorization	Name	Signature	Date
Board Chair	Myron E. Mackla		2/5/2015
Executive Director			

Attachment(s):

A: *Opt-Out Form (page 3)*
B: *Opt-Out Revocation Form (page 5)*
C: *Opt-Out Processing Log (page 7)*
D: *Processed Opt-Out Response Form (page 8)*

Version	Date	Author	Comment
.001	02/02/2015	E. Steffen/ J. Helvey/M. Jensen/K. Dorsey-Tyler	Initial release.

Attachment A: Health Information Exchange Opt-Out Request (2 page Publisher Document)

SACVALLEY MEDSHARE

The Health Information Exchange for California's North Central Valley

MR#: **Patient Name:** **DOB:**

Health Information Exchange (HIE) is the sharing of health information electronically across organizations. SacValley MedShare (SVMS) operates an HIE Network among SVMS regions and participates in several HIE networks with other health care providers outside of SVMS and may share your health information electronically with other organizations such as public health departments, health plans, health care providers, and other participants. Exchanging information electronically is a faster way to share your health information with health care providers treating you. For example, if you go to a hospital emergency room that participates in the same HIE network as SVMS, the emergency room physicians would be able to access your SVMS health information to help make treatment decisions for you. HIE participants like SVMS are required to meet rules that protect the privacy and security of your health and personal information.

If you do not want your health information shared through an HIE network, please complete this form and return it to the address below. By completing this form, you request that SVMS not share your health information electronically through Health Information Exchange with any other regions or outside organizations. At this time, if you decide to Opt Out of exchanging your information, none of your information will be shared through a SVMS HIE network., even in an emergency. In other words, opting out is an all "all or nothing" concept. A request to opt out of an HIE will be effective approximately five (5) business days after receipt by SVMS, and will not apply to any information sent through the HIE or exchanged with other participants in an HIE network before that date. You are free to opt back in at any time by completing an Opt-Out Revocation Form that can be obtained from Membership Services or downloaded from http://sacvalleyms.org.

A separate form must be completed by each family member wishing to Opt Out. Please complete all of the below required fields for accurate processing. Print legibly with a black ball point pen.

SVMS-FORM-002.002 Opt-Out Form Page 1 of 2

Health Information Exchange Opt-Out Request (Page 2)

SACVALLEY MEDSHARE

The Health Information Exchange for California's North Central Valley

Health Information Exchange Opt-Out Request

MR#: **Patient Name:** **DOB:**

First Name MI Last Name DOB

Mailing Address (Street Address, City, State, Zip Code)

Telephone Number Medical Record Number

Signature (Required) Date

Print Authorized Representative's Name Relationship to Patient

Please Mail Completed Form To:

SacValley MedShare, 1448 Esplanade, Chico CA95926

SVMS-FORM-002.002 Opt-Out Form Page 2 of 2

Attachment B: Health Information Exchange Opt-Out Revocation Request (2 page Publisher Document)

SACVALLEY MEDSHARE

The Health Information Exchange for California's North Central Valley

Health Information Exchange Opt Out Revocation Request

MR#: **Patient Name:** **DOB:**

I hereby acknowledge and agree as follows:

1. I WISH TO REVOKE (change) my prior decision to Opt-Out of the SacValley MedShare HIE, and now **specifically AUTHORIZE** my information maintained in the SacValley MedShare HIE to be electronically available to my providers;

2. I UNDERSTAND that by making this selection, now ALL of my authorized providers who participate in the SacValley MedShare HIE or are connected to the SacValley MedShare HIE will have access to my health information maintained in the SacValley MedShare HIE;

3. I UNDERSTAND that by making this selection, my health information may be accessible by other Connected HIEs with whom the SacValley MedShare HIE participates.

4. I UNDERSTAND that this Revocation can only be changed if I specifically submit a new HIE Opt-Out form;

5. I have had an opportunity to have all my questions regarding this "Revocation of Prior Opt-Out" and others answered;

6. This request can take **5 business days from receipt** to take effect.

Please complete the next page, your request cannot be completed otherwise.

SVMS-FORM-002.002 Opt-Out Revocation Form Page 1 of 2

Health Information Exchange Opt-Out Revocation Request (Page 2)

SACVALLEY MEDSHARE

The Health Information Exchange for California's North Central Valley

First Name MI Last Name DOB

Mailing Address (Street Address, City, State, Zip Code)

Telephone Number Medical Record Number

Signature (Required) Date

Print Authorized Representative's Name Relationship to Patient

Please Mail Completed Form To:

SacValley MedShare, 1448 Esplanade, Chico CA 95926

SVMS-FORM-003.002 Opt-Out Revocation Form Page 2 of 2

Attachment C: Opt-Out Processing Log (Excel Workbook)

SacValley MedShare Opt-Out Processing Log

Date Received	Method of Receipt	Received From (Part. Or Pt)	Processed By	Participant Name	Patient Name	Processed on ICA Side	Date Processed on ICA	Form Archived	Opt-Out Ack Form Sent to Pt	Notes	
1/8/2015	US Mail	Participant	ES	Big Hospital	Sally Patient	Y	1/9/2015	Y	1/19/2015	n/a	*Example*
1/8/2015	email	Patient	ES	Dr. Provider	Susan E. Patient	N	n/a	Y	1/19/2015	received form not signed, Pt contacted 1/9/15 @ 1345, Pt will send new form	*Example*

SVMS-FORM-006-001-OptOutProcessingLog.xlsx

Attachment D: Processed Opt-Out Response Form (1 page Publisher Document)

SACVALLEY MEDSHARE

The Health Information Exchange for California's North Central Valley

Response to Opt-Out Request

Your request for opting-out of having your patient information available on the SacValley MedShare Health Information Exchange has been received and processed.

You recognize that when you see a physician for treatment outside of SacValley MedShare, that physician may request and receive your medical information from SVMS through other methods, such as fax or mail.

Opt-Out Processed For:

First Name MI Last Name DOB

Mailing Address (Street Address, City, State, Zip Code)

Telephone Number Medical Record Number

Processed By:

Signature Name/Title Date

SVMS-FORM-010.002 Opt-Out Revocation Form