Authorization for Use and Disclosure of Medical Information
For eClinicalWorks

I, _____ [INSERT NAME OF PATIENT], a patient at CCACC-Pan Asian Volunteer Health Clinic ("My Clinic") understand that eClinicalWorks is a computer-based health information exchange comprised of member healthcare providers like My Clinic (members of eClinicalWorks are called "eCW Members") whose purpose is to provide improved health care to individuals like me by allowing providers who treat me to have access to my medical records. I understand that, unless I notify My Clinic that my medical information may no longer be shared with eClinicalWorks, my medical information (as defined below) will be provided to eClinicalWorks and will be available to eCW Members for purposes of providing me with health care services as further described below, and as otherwise may be permitted by law. However, I understand that even if I notify My Clinic requesting that my medical information no longer be shared, my medical information will continue to be available to eCW Members through eClinicalWorks in certain limited situations as permitted by law (for example, in order to avert a serious threat to the health and safety of myself or others).

- *Purpose of use or disclosure of my medical information.* I am authorizing the sharing of my medical information with eClinicalWorks, which allows eCW Members to more easily share my medical information, as defined below, for the purpose of providing me with health care services.
- *Information that is covered by this Authorization.* This Authorization covers information about me that is created or received by My Clinic, as well as other eCW Members, in the course of providing health care services to me, including but not limited to medical, personal and family household information (together called "my medical information"). This Authorization also covers medical information that eCW Members receive from other providers.
- *Who may receive, use, or disclose my medical information.* I am authorizing only eClinicalWorks to receive, use and disclose my medical information among eCW Members, including their staff. This Authorization does not allow the disclosure of my medical information to individuals or entities other than eClinicalWorks and eCW Members, except as otherwise permitted or required under federal or state law.
- *Term of Authorization.* This Authorization will remain in effect, unless revoked by me, for a period of ten (10) years from the date I sign this Authorization or any shorter period that may be required by law.

I understand that I may at any time make a written request to My Clinic, or any other eCW Member, to inspect or obtain a copy of my medical information and that the eCW Member will either contact me for a convenient time to inspect or copy my medical information or provide me with a copy or summary of my medical information. I further understand that I may obtain from My Clinic or any other eCW Member a complete list of eCW Members. I understand that a copy of this Authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original health records.

I understand that the medical information disclosed under this Authorization might be redisclosed by a recipient and may, as a result of such disclosure, no longer be protected by law to the same extent as such medical information was protected by law while solely in the possession of the eCW Member.

I understand that I may refuse to sign this Authorization at any time for any reason and that my refusal to sign this Authorization will not affect the commencement, continuation or quality of treatment of me by My Clinic or any other eCW Members, unless otherwise permitted by law.

I understand that eCW Members will not sell or receive compensation for the use or disclosure of medical information that is identifiable to me.

I understand that I may revoke this Authorization at any time and that such revocation will not affect the commencement, continuation or quality of treatment of me by eCW Members. In order to revoke this Authorization, I understand that I should submit to My Clinic or any other eCW Member a written request to revoke this Authorization. The revocation will be effective upon receipt by an eCW Member of my written request to revoke, except to the extent that action already has been taken in reliance on this Authorization.

I have read and understood the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my medical information. Accordingly, I knowingly and voluntarily authorize any eCW Member to use or disclose my medical information in the manner described above. I understand and agree that this Authorization applies only to the extent that an Authorization is required by law in order for eCW Members to use or disclose my medical information in the manner described above.

I understand that I can notify My Clinic or any other eCW Member at anytime of my wish to revoke this Authorization and no longer share my health information electronically.

_____ _____

Signature of Patient Date

If the patient is a minor or otherwise unable to sign this Authorization, please complete the following and provide a copy of documentation that authorizes you to act as the personal representative:

_____ _____

Signature of Personal Representative Relationship Date