Southeast Texas Ear, Nose & Throat, LLP/Facial Plastic Surgery of Beaumont
Healthconnect Patient Consent/Withdrawal Form

Patient Name:_____ **DOB:**_____

Purpose

Healthconnect provides a way to share your health information among participating doctor's offices, hospitals, labs, radiology centers, and payers of health claims such as health insurers through secure, electronic means. The purpose of this form is to allow you to permit each of your participating caregivers access to the most up to date information in your health record. When you choose to participate in Healthconnect, doctors and other healthcare providers will be able to search for your health information through Healthconnect and use it while treating you. By signing this Patient Consent Form, you agree that Healthconnect, your health care provider, and other members of Healthconnect may use and disclose you protected health information for the limited purpose of treatment, payment and health care operations. It does not change who gets to review your information or the kinds of information shared.

I understand that I have the right to make informed decisions about the electronic disclosure of my health information.

Effective Period

The consent will remain in effect until I withdraw my permission.

Consent Given/Ability to Withdraw Permission

I understand I can withdraw my permission at any time by giving written notice at any of my healthcare providers participating with Healthconnect. I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission. I have been given a copy of the Health Information Exchange Policy, or had the policy read and explained to me. I sign this form as my consent.

_____ _____
Patient Authorized Agent, If applicable

_____ _____
Date Relationship to patient

~~~~~~

To be completed only if withdrawing from Healthconnect

Decision to Withdraw: I understand that I previously gave consent to one of my providers participating in Healthconnect to share my health information to other providers within Healthconnect. However, after consideration, I have made the decision to withdraw this authorization by my signature below. I understand this change will be provided to Healthconnect and unless I change my mind, my providers will not be able to view my health record for continuity of care through electronic means of Healthconnect.

_____ _____
Patient Authorized Agent, If applicable

_____ _____
Date Relationship to patient
~~~~~~