

HEALTH INFORMATION EXCHANGE OF ELECTRONIC NEWBORN SCREENING RESULTS

CLINICIAN HIE CONSENT FORM

INSTRUCTIONS: This form is for clinicians to notify the State of California, Department of Public Health, Genetic Disease Screening Program (GDSP) where to send their health information exchange (HIE). Written consent is required for data to be sent to a Health Practice Management firm or a Physician/Medical group.

CLINICIAN INFORMATION

FIRST NAME		LAST NAME	
TYPE OF CLINICIAN <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> MIDWIFE		LICENSE #:	NPI #:

DATA TRANSMISSION PREFERENCE

HOW WOULD YOU LIKE TO RECEIVE THE NEWBORN SCREENING RESULTS?	<input type="checkbox"/> PDF MAILER ONLY	<input type="checkbox"/> ELECTRONIC HL7 MAILER	<input type="checkbox"/> BOTH PDF AND ELECTRONIC HL7 MAILER	EFFECTIVE DATE:
--	--	--	---	-----------------

AGENCY YOU WANT TO RECEIVE YOUR HIE

CURRENTLY THE STATE IS ONLY ABLE TO SEND HIE TO ONE AGENCY

ADD	NAME OF HEALTH PRACTICE MANAGEMENT OR PHYSICIAN/MEDICAL GROUP:			EFFECTIVE DATE:	
	STREET ADDRESS		CITY	STATE	ZIP
	EMAIL ADDRESS		TELEPHONE NUMBER <i>(With area code)</i>		EXTENSION

REMOVE	NAME OF HEALTH PRACTICE MANAGEMENT OR PHYSICIAN/MEDICAL GROUP:			EFFECTIVE DATE:	
	STREET ADDRESS		CITY	STATE	ZIP
	EMAIL ADDRESS		TELEPHONE NUMBER <i>(With area code)</i>		EXTENSION

AUTHORIZATION AND APPROVAL

THE UNDERSIGNED HEREBY AUTHORIZE AND APPROVE THE TRANSMISSION OF ELECTRONIC HEALTH INFORMATION FOR THE NEWBORN SCREENING RESULTS TO THE ABOVE NAMED AGENCY FOR THE LIST OF OFFICE ADDRESSES ON THE REVERSE OF THIS PAGE.

NAME PRINTED	SIGNATURE	DATE SIGNED (MM/DD/YYYY)
--------------	-----------	--------------------------

ON PAGE TWO OF THIS FORM LIST ALL OFFICE ADDRESSES THAT YOU ARE ASSOCIATED WITH THAT THE AGENCY YOU ARE GIVING CONSENT TO RECEIVE YOUR HIE

OFFICES/FACILITIES THAT THE HIE RECEIVER WILL BE COLLECTING

HIE RESULTS WILL BE LINKED TO THESE SPECIFIC ADDRESSES

FACILITY NAME			STREET ADDRESS		STATUS CHANGE: ADD <input type="checkbox"/> REMOVE <input type="checkbox"/>	
#1	CITY	STATE	ZIP	TELEPHONE NUMBER <i>(With area code)</i>	EXTENSION	EFFECTIVE DATE:
FACILITY NAME			STREET ADDRESS		STATUS CHANGE: ADD <input type="checkbox"/> REMOVE <input type="checkbox"/>	
#2	CITY	STATE	ZIP	TELEPHONE NUMBER <i>(With area code)</i>	EXTENSION	EFFECTIVE DATE:
FACILITY NAME			STREET ADDRESS		STATUS CHANGE: ADD <input type="checkbox"/> REMOVE <input type="checkbox"/>	
#3	CITY	STATE	ZIP	TELEPHONE NUMBER <i>(With area code)</i>	EXTENSION	EFFECTIVE DATE:
FACILITY NAME			STREET ADDRESS		STATUS CHANGE: ADD <input type="checkbox"/> REMOVE <input type="checkbox"/>	
#4	CITY	STATE	ZIP	TELEPHONE NUMBER <i>(With area code)</i>	EXTENSION	EFFECTIVE DATE:
FACILITY NAME			STREET ADDRESS		STATUS CHANGE: ADD <input type="checkbox"/> REMOVE <input type="checkbox"/>	
#5	CITY	STATE	ZIP	TELEPHONE NUMBER <i>(With area code)</i>	EXTENSION	EFFECTIVE DATE:
FACILITY NAME			STREET ADDRESS		STATUS CHANGE: ADD <input type="checkbox"/> REMOVE <input type="checkbox"/>	
#6	CITY	STATE	ZIP	TELEPHONE NUMBER <i>(With area code)</i>	EXTENSION	EFFECTIVE DATE:
FACILITY NAME			STREET ADDRESS		STATUS CHANGE: ADD <input type="checkbox"/> REMOVE <input type="checkbox"/>	
#7	CITY	STATE	ZIP	TELEPHONE NUMBER <i>(With area code)</i>	EXTENSION	EFFECTIVE DATE:
FACILITY NAME			STREET ADDRESS		STATUS CHANGE: ADD <input type="checkbox"/> REMOVE <input type="checkbox"/>	
#8	CITY	STATE	ZIP	TELEPHONE NUMBER <i>(With area code)</i>	EXTENSION	EFFECTIVE DATE:

GENETIC DISEASE SCREENING PROGRAM • NEWBORN SCREENING BRANCH • 850 MARINA BAY PARKWAY, F175 • RICHMOND, CA 94804

Website: www.cdph.ca.gov/programs/nbs • E-mail questions to: NBS.Results@cdph.ca.gov • PHONE: 510/412-1541 • FAX: 510/412-1559

FOR OFFICE USE ONLY: