WISHIN Pulse

Health Information Exchange: A Guide to Patient Choice

What is a Health Information Exchange?

Health information exchange (HIE) is a way to share your essential health information among participating doctors' office, hospitals, labs, radiology centers and other health care providers through secure, electronic means. The Wisconsin Statewide Health Information Network, Inc. (WISHIN) was chosen by the state of Wisconsin to govern and implement our state's health information exchange, which is called WISHIN Pulse.

WISHIN Pulse helps every participating provider you see gain timely access to a more complete and accurate health record. That helps your doctors and other caregivers work together more easily, make better decisions about your care, eliminate redundant forms or tests, and reduce mistakes-especially in an emergency or for providers outside your typical health network.

Is Sharing Health Information Something New?

No. Today, health information is frequently shared between doctors through phone calls, faxes or US mail. WISHIN Pulse allows this same information to be shared securely and electronically-making it more cost-effective, timely and efficient that current paper-based methods.

What Information Is In WISHIN Pulse?

WISHIN Pulse includes essential health information from health care providers who have treated you and are WISHIN participants. That information includes medications, allergies, current and past test results, and summaries of past and current health problems. WISHIN Pulse can provide a summary view of this information, which will enable better decisions about your health care.

How Is My Information Protected?

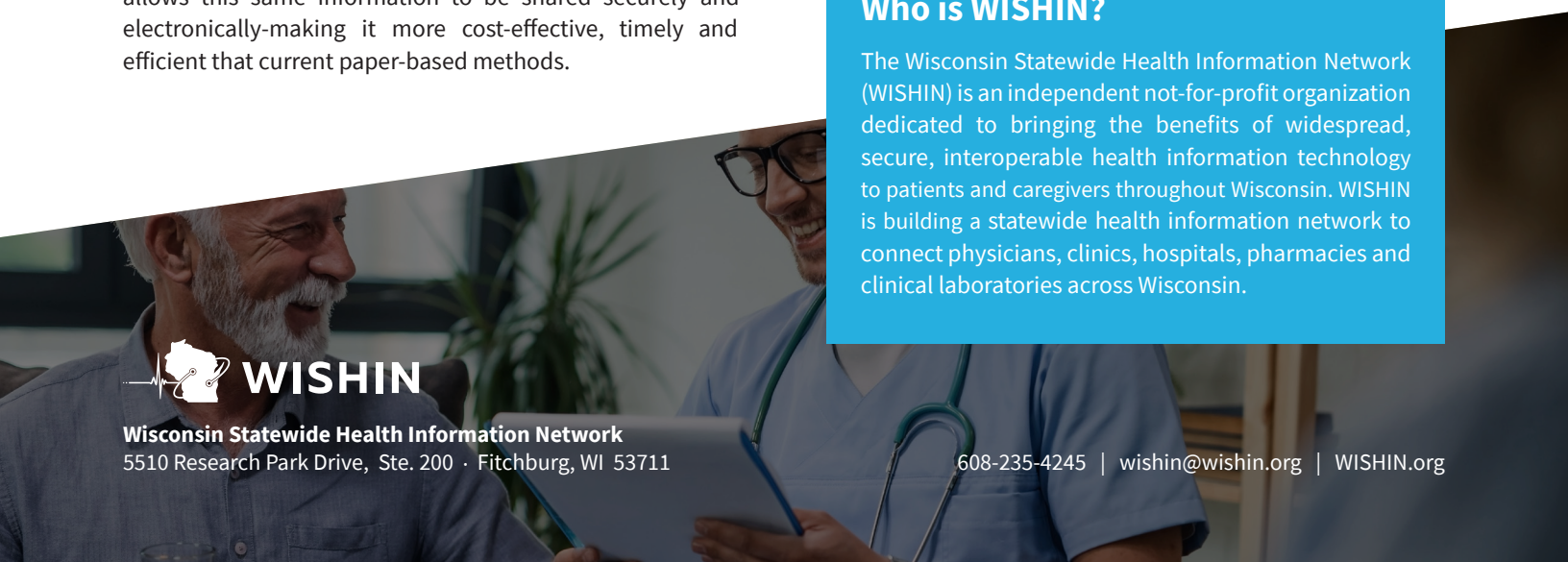
WISHIN Pulse carefully protects the privacy and security of your records. First, WISHIN and all participating WISHIN providers must comply with the policies, procedures, and regulations established by the Health Insurance Portability and Accountability Act of 1996 (HIPPA) as well as other applicable laws and regulations. Some health information (such as mental health, alcohol, or drug treatments, etc.) requires additional written consent from you before it can be shared with your doctor, except in an emergency.

Only those involved in your care will be able to view your health information, and only when needed to provided or coordinate your care, make referrals or submit required public health information (such as your vaccination history). Audit logs, reports and other security measures show how health information has been accessed or exchanged. These reports support compliance with the strict federal and state guidelines that govern how and when your health information can be exchanged, viewed, or used. Information that identifies you will never be sold or made available for other purposes.

Together, these security measures make an electronic health information exchange more secure than today's paper-based exchange methods such as fax or courier.

Who is WISHIN?

The Wisconsin Statewide Health Information Network (WISHIN) is an independent not-for-profit organization dedicated to bringing the benefits of widespread, secure, interoperable health information technology to patients and caregivers throughout Wisconsin. WISHIN is building a statewide health information network to connect physicians, clinics, hospitals, pharmacies and clinical laboratories across Wisconsin.



WISHIN
Wisconsin Statewide Health Information Network
5510 Research Park Drive, Ste. 200 · Fitchburg, WI 53711
608-235-4245 | wishin@wishin.org | WISHIN.org

Do I Have a Choice?

Yes; you decide if you wish to participate or not, and you can change that decision at any time. **If you want to be sure that your providers have timely and secure access to your health information electronically through WISHIN Pulse, you don't have to do a thing. Participation is automatic.**

However, you can choose NOT to participate in Wisconsin's health information exchange. That means your doctors will **not** be able to access your health information through WISHIN Pulse to use while treating you, except in cases of an emergency, for public health reporting as permitted by law, and for your medication list. This is called "opting out." If you opt out, you must accept the risks associated with denying your doctors access to your health information through WISHIN Pulse (see Opt-Out Stipulations). To opt out, you must complete and submit the attached Patient Choice Form. It may take up to three business days after we receive your form before your opt-out request will take effect.

You will receive confirmation of your request by mail from the Wisconsin Statewide Health Information Network (WISHIN). Retain that confirmation for your records. If you do not receive confirmation, contact WISHIN Support at 608-235-4245 as soon as possible.

All information fields must be completed. For your protection, each request received is subject to verification. Incomplete forms may result in additional delay or denial of your request. Access to your health information through WISHIN Pulse will be restricted as soon as is practical.

Need more information before making your decision? **Visit www.wishin.org, call 608-235-4245 or email support@wishin.org.**

Opt-Out Stipulations

You must read, understand and accept these stipulations in order to officially opt out. You must initial your Patient Choice Form, under Opt-Out Certification, to indicate your acceptance.

1. I UNDERSTAND that this request only applies to sharing my health information through WISHIN Pulse. I UNDERSTAND that when I see a health care provider for treatment, that provider may request and receive my medical information from other providers using other methods permitted by law, such as fax or mail. I am aware that health care providers who originally recorded information about me may continue to have access to this information through means other than WISHIN Pulse.

2. I UNDERSTAND that once my opt-out request goes into effect, it will remain in effect unless I change it in writing by submitting an opt-back-in request to WISHIN via a Patient Choice Form.

3. I have had an opportunity to ask and receive answers to all my questions about opting out of WISHIN Pulse.

4. Any information that is disclosed before I submit this opt-out request cannot be taken back and may remain with my provider if he/she accessed such information before this request went into effect.

5. This request, and any future request to opt back in, can take up to three business days after receipt by WISHIN to take effect.

6. I UNDERSTAND that this WISHIN Pulse opt-out request does NOT cover or affect my opting out of any other health information exchanges, including other exchange technologies offered by WISHIN.

7. I UNDERSTAND that if I wish to opt out of another health information exchange, I must follow the instructions of the other such exchanges to limit my participation.

8. I UNDERSTAND and accept the risks associated with denying health care providers access to my health information through WISHIN Pulse.

9. I UNDERSTAND that I can revoke this request at any time.

Patient Choice Form

To take part in WISHIN Pulse, you don't need to do anything. This form is required only for two circumstances:

1. You choose NOT to allow your health information to be exchanged through WISHIN Pulse (i.e., you choose to opt out), or
2. You had previously chosen to opt out but would like to change that decision and opt back in so that your doctors can securely access your health information through WISHIN Pulse.

Patient Choice Form

You must complete the entire Patient Choice Form and have your signature witnessed by a friend or family member. Forms cannot be processed without a witness's signature.

Please mail completed forms to:

WISHIN
Attn: Opt-Out Request
5510 Research Park Dr, Ste 200
Fitchburg, WI 53711

◯ OPT-OUT REQUEST: I wish to OPT OUT of having my essential health information shared through WISHIN Pulse. I understand that by making this decision, doctors and caregivers will not be able to access my health information through WISHIN Pulse, except in cases of a medical emergency or as necessary to report specific information to a government agency as permitted by law (for example, reporting of certain communicable diseases or suspected incidents of abuse).

◯ OPT BACK IN: I wish to terminate my previous request to opt out of having my essential health information shared through WISHIN Pulse. My health information will be available to my doctors and caregivers.

*All fields must be completed in order for WISHIN to process your request.
All information on this form remains strictly confidential and will be used solely for the purpose of carrying out your request.

Please Print

***Full Name:**

First/Middle/Last

***Date of Birth:**	***Gender:**	***Phone #:**
Month/Date/Year	◯ Male ◯ Female	(XXX)XXX-XXXX

***Street Address:**

***City/State/ZIP:**

Opt-Out Certification	**Reason for Opt-Out Request:**
Please initial here _____ to certify that you have read and accept the opt-out stipulations in this brochure.	

***Signature of Patient (or Authorized Representative)**	***Date**

For your protection, WISHIN requires a witness's signature to help verify your identity. The witness can be anyone who can confirm you signed the form.

***Signature of Witness**	***Date**	***Relationship to Patient**

If you are completing this request as the personal representative for another patient, you must also provide the following information about yourself:

***Relationship to Patient:**	**Title:**	***First Name:**	***Middle Name:**	***Last Name:**	**Suffix**
	(Mr./Mrs./Miss/Ms./Dr.):				(Jr., Sr., III, etc.):

***Address:**	***City/State/ZIP:**

Email Address:	***Primary Phone:**	**Alternate Phone:**
	(XXX)XXX-XXXX	(XXX)XXX-XXXX

(Confirmation of this request will be sent to the email address listed here)

*Preferred method of contact – check only one (in case WISHIN requires additional information to implement your request):

◯ Mail ◯ Email ◯ Primary Phone ◯ Alternate Phone