Attestation: Florida HIE Participant Notice of Privacy Practices (NPP) & NPP Acknowledgement

The Florida Health Information Exchange (Florida HIE) technology platform is provided by CRISP Shared Services (CSS). Pursuant to the CRISP Shared Services (CSS) Policies and Procedures, each Participant must adequately educate patients on the ability to opt-out of data sharing and the opt-out process. Each Participant must ensure that the Participant's Notice of Privacy Practices are updated to facilitate this education process. We recommend the language below.

Suggested Update to Notice of Privacy Practices

We participate in the Florida Health Information Exchange (Florida HIE). As permitted by law, your health information will be shared with this exchange to provide faster access, better coordination of care, and to assist providers and public health officials in making more informed decisions. You may "opt out" and disable access to your health information available through CRISP Shared Services by calling 877-940-6144 or completing and submitting an Opt-Out form to the Florida HIE by mail, fax, or through their website at www.flhie.org.

Suggested Update to NPP Acknowledgement Page

We participate in the Florida Health Information Exchange (Florida HIE) to share your medical records with your treating providers, health plans, third-party payers, and other organizations helping to coordinate your care. You have rights to limit how your medical information is shared. We encourage you to read our Notice of Privacy Practices and find more information about the Florida HIE's medical record sharing policies at www.flhie.org.

Patient Authorization Language

In addition, to receive the full set of services offered by the Florida HIE, each patient must have a signed consent as provided in s 408.051(7), F.S.

Please attest that your patient consent form includes language similar to the following:

By signing this form, I voluntarily authorize and give my permission and allow disclosure:

OF WHAT: ALL MY HEALTH INFORMATION including any information about sensitive conditions (if any).

FROM WHOM: ALL information sources.

TO WHOM: The Florida HIE, who may then disclose the information to any of my treating providers, health plans, third-party payers, and other organizations helping to coordinate my care. I can request a list of those who have received my information by going to https://disclosures.crisphealth.org.

PURPOSE: To provide me with medical treatment and related services, including health care operations, and to help pay for any of the services I received. I also understand that my data may be shared as required by law for public health purposes.

Any health information about you may be re-disclosed to others only to the extent permitted by state and federal laws and regulations. You understand that once your information is disclosed, it may be subject to lawful re-disclosure, in accordance with applicable state and federal law, and in some cases, may no longer be protected by federal privacy law.

By signing the below, I attest that our Notice of Privacy Practices is in accordance with the above or in a way that captures the relevant information presented above.

Participant Organization: _____

Name: _____

Signature: _____

Date: _____

Email Address: _____

This document is not a comprehensive representation of the Participant's obligations to a consumer under federal and state laws and regulations. Participants should complete their own legal review for sufficiency.