PARTNERS HEALTHCARE | FOUNDED BY BRIGHAM AND WOMEN'S HOSPITAL AND MASSACHUSETTS GENERAL HOSPITAL

PATIENT IDENTIFICATION AREA

( ) HHK
( ) BP
( ) YO
( ) ML

PATIENT CONSENT/OPT-IN TO THE MASSACHUSETTS HEALTH INFORMATION HIGHWAY (Mass HIway)

The Mass HIway is a secure, statewide network that allows my healthcare providers to safely and quickly share important information about me when and where it is needed for my care (such as my allergies, medications, and health history) with the goal of improving communication among hospitals and doctors and providing better quality care to patients.

Partners HealthCare System, Inc. ("Partners HealthCare") and/or its affiliated entities and healthcare providers have provided me with information about the Mass HIway. I understand that Partners HealthCare has developed an integrated electronic medical record that is used by Partners HealthCare, its affiliated entities and healthcare providers and other non-partners healthcare providers such as Dana-Farber Cancer Institute, Massachusetts Eye and Ear Infirmary and certain community physicians and physician groups. I acknowledge that by signing this form below I consent to and agree that Partners HealthCare and its affiliated entities and healthcare providers and all other users of the Partners integrated electronic medical record (including but not limited to Dana-Farber Cancer Institute and Massachusetts Eye and Ear Infirmary) may request, access, send and receive my health information using the Mass HIway. I understand that the information accessed or shared using the Mass HIway may also include information created by other healthcare providers and organizations and used by Partners HealthCare and/or its affiliated entities and healthcare providers to provide care to me.

I understand that I can withdraw my consent to share my health information using the Mass HIway at any time by contacting any of the Partners HealthCare hospital privacy offices and completing the Partners HealthCare Mass HIway OPT-OUT form.

Patient Name (Print):	Date:
Patient Signature:	Date of Birth:

When the patient is a minor, or is unable to give consent, the signature of a parent, guardian, or other representative is required.	
Signature of Representative:	Date:
Print Name:	Relationship to patient: