WISHIN Pulse

Health Information. Stat.

Health Information Exchange: A GUIDE TO PATIENT CHOICE

Who is WISHIN?

The Wisconsin Statewide Health Information Network (WISHIN) is an independent not-for-profit organization dedicated to bringing the benefits of 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.

Our vision is to promote and improve the health of individuals and communities in Wisconsin through the development of information-sharing services that facilitate electronic delivery of the right health information at the right place and right time to the right individuals.

WISHIN

Wisconsin Statewide Health Information Network
PO Box 259038
Madison, WI 53725-9038
Phone: 608.274.1820 | Email: wishin@wishin.org

What is a Health Information Exchange?

Health information exchange (HIE) is a way to share your essential health information among participating doctors' offices, hospitals, labs, radiology centers and other health care providers through secure, electronic means. The Wisconsin Statewide Health Information Network (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 postal courier. WISHIN Pulse allows this same information to be shared securely and electronically— making it more cost-effective, timely and efficient than current paper-based methods.

What Information is in WISHIN Pulse?

WISHIN Pulse gives your doctor a summary view of essential health information from all participating doctors who have taken care of you. This includes medications, allergies, current and past test results, and summaries of past and current health problems.

How is My Information Protected?

WISHIN Pulse takes every precaution to keep your records private and secure. 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 (HIPAA) 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 disclosed to your doctor, except in an emergency.

Only those who care for you will be able to view your health information, and only when needed to provide or coordinate your care, make referrals, submit mandatory public health reports (such as your vaccination history), or to provide health care benefits to you. Audit logs, reports and other security measures are used to provide transparency in how health information has been accessed or exchanged, and ensures adherence to the clear and 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.

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 and for public health reporting that is required by law. 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 1-888-WISHIN1 as soon as possible.

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

Need more information before making your decision?

Visit www.wishin.org, call 608.274.1820 or email wishin.support@wishin.org.

Opt-Out Stipulations

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

1. I UNDERSTAND that even if I opt out, providers who originally recorded information about me will continue to have access to my information, but only in the medical record that *they* created for me, not through 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 will 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 to take effect.
6. I UNDERSTAND this request only applies to sharing my health information through Wisconsin's WISHIN Pulse system. I recognize 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.
7. I UNDERSTAND that this WISHIN Pulse opt-out request does NOT cover or effect my opting out of any other health information exchanges, including other exchange technologies offered by WISHIN.
8. I UNDERSTAND that if I wish to opt out of another health information exchange, I am responsible for approaching my provider participating in such other exchanges about how I can do that.
9. I UNDERSTAND and accept the risks associated with denying health care providers access to my health information through WISHIN Pulse.
10. I UNDERSTAND that I can revoke this restriction at any time.

Patient Choice Form

To take part in WISHIN Pulse, you don't need to do anything. The form below 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.

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
PO Box 259038
Madison, WI 53725-9038

◯ 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 required 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 now be available to my doctors and caregivers.

* All fields must be filled out in order for WISHIN to process your request.

All information 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 that 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 individual, you must also provide the following information about yourself:

***Relationship to Individual:**	**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 e-mail address listed here)

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

◯ Mail ◯ Email ◯ Primary Phone ◯ Alternate Phone

◯ Check here if you are a 42 C.F.R. Part 2 Program submitting Request for Restriction on behalf of a patient.