

Application Form to Opt Out of the National Health Information Exchange Network for a Legally Unfit Person

Applicant's Declaration

IGiv	ven Name	Surname	ID No.	
Gender: M/F	Date of Birth:		Address:	
Guardian for	health matters	s of:		
Given Na	me Surname	ID No]-[]
Gender: M/F	Date of Birth:		Address:	
		•	nderstood the following:	hereby declare that:

- a. The National Health Information Exchange Network allows the display of medical information to a treatment provider in hospitals throughout Israel from the medical file of the legally unfit person under my responsibility that is stored in the information systems of the institutions in which he/she has been treated - other hospitals and the HMO (kupat cholim).
- b. Systems to protect the confidentiality of information have been set up in the information exchange system, and the system monitors each viewing of the medical file of the legally unfit person under my responsibility and documents it.
- c. The significance of a request to remove the legally unfit person under my responsibility from the network is that the medical information about him/her (from hospitals and the HMO-kupat cholim) that is available through the information exchange network will not be available to those treating him/her, and the treatment provider will have to rely exclusively upon information that I will provide regarding his/her medical history, medications that he/she is taking, sensitivities to medications, etc. In case I will not be able to provide the treatment provider with the above-detailed information, the party treating the legally unfit person under my responsibility will not have access to medical information about him/her from other organizations.
- 2. I understand that it is my personal and full responsibility to inform the treatment providers of the needed medical history of the legally unfit person under my responsibility, including sensitivities, the medications that he/she is taking, medical procedures that he/she has undergone, test results, and similarly, all other medical information.
- 3. I am aware that after my request is carried out, information regarding the legally unfit person under my responsibility will be removed from the network in its entirety, and that it is not possible to opt out partially or to remove only a portion of the information. In all events, it will not be possible in hospital to view information that exists about him/her in other health organizations.
- 4. I am aware that in spite of opting out of the network, a summary of an emergency room visit or of hospitalization of the legally unfit person under my responsibility will continue to be sent



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from the hospital to the insuring HMO (kupat cholim), as has been the case until now, irrespective of the medical information exchange network.

- 5. In spite of being aware of the possible implications, I request to remove the legally unfit person under my responsibility from the information exchange network.
- 6. If I will wish to change my mind, I will have to sign an application form for reinstatement (to opt back in) at a branch of the HMO (kupat cholim).
- 7. The actual removal of the legally unfit person under my responsibility from the network will be carried out within 30 days of the submission of the application to a branch of the HMO (kupat cholim).
- 8. On transfer of the legally unfit person under my responsibility between HMOs (kupot cholim), I will have to resubmit the request to remove him/her from the network at the HMO (kupat cholim) to which he/she transfers, this being for the HMO's administrative requirements.

Guardian's Name:	Signature:	Date:	
Telephone number for clarification	ns (not compulsory):		
Email address for clarifications (n	ot compulsory):	@	
(Signature verification on the next	nage)		



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Signature Verification						
I, the undersigned		Position				
Branch		District				
certify that Given Name	Surname	ID No.				
Guardian for health matters of:						
Given Name Surname	ID No.					
appeared before me and identified h	im/herself using an i	identity document, presented a valid				
guardianship order, received an info	rmation sheet about	the National Information Exchange				
Network and about the significance	of opting out of the	network, and signed this form in my				
presence.						
Name:	Signature:	Date:				