Application Form to be Reinstated (Opt back In) to the National Health Information Exchange Network for a Legally Unfit Person

Applicant's Declaration

I _____ _____ ID No. ☐☐☐☐☐☐☐☐-☐
Given Name Surname

Gender: M/F Date of Birth: _____ Address: _____

Guardian for health matters of:

_____ _____ ID No. ☐☐☐☐☐☐☐☐-☐
Given Name Surname

Gender: M/F Date of Birth: _____ Address: _____

Insured in HMO (Kupat Cholim) _____ hereby declare that:

1. I am aware that 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).
2. I understand that the aim of transferring information in the network is for the purpose of improving the quality of the medical treatment given to the legally unfit person under my responsibility, with the party treating him/her being able to know his/her medical history, the medications that he/she is taking, procedures that he/she has undergone, test results and the like, with the exception of sensitive information that has been defined as protected information, which will not be conveyed in the network.
3. Even though I have in the past requested to remove the legally unfit person under my responsibility from the network (opt out), I now request to reinstate him/her (opt back in), and to enable a medical party treating him/her to view information from his/her medical file in other health institutions.
4. When he/she is reinstated, all the information that exists in the computerized system of each institution will be conveyed to the network, including information that was documented during the period in which I requested to remove him/her from the network.
5. The reinstatement of the legally unfit person under my responsibility to the network will be carried out within 30 days of submission of the application to the HMO (kupat cholim).

Guardian's Name: _____ Signature: _____ Date: _____

Telephone number for clarifications (not compulsory): _____

Email address for clarifications (not compulsory):_____@_____

Signature Verification

I, the undersigned _____ Position: _____

Branch:_____ District: _____

certify that _____ _____ ID No. ☐☐☐☐☐☐☐☐-☐
Given Name Surname

Application Form to be Reinstated (Opt back In) to the National Health Information Exchange Network for a Legally Unfit Person

Guardian for health matters of:

_____ _____ ID No. ☐☐☐☐☐☐☐☐-☐

Given Name Surname

appeared before me and identified him/herself using an identity document, presented a valid guardianship order, and signed this form in my presence.

Name: _____ Signature: _____ Date: _____