Application Form to be Reinstated (Opt back In) to the National Health Information Exchange Network, Up To Age 18

Applicants' Declaration

I ____________ ____________________ ID No. ☐☐☐☐☐☐☐☐-☐
Given Name Surname

Gender: M/F Date of Birth: ______________ Address: ________________________________

I ____________ ____________________ ID No. ☐☐☐☐☐☐☐☐-☐
Given Name Surname

Gender: M/F Date of Birth: ______________ Address: ________________________________

The parents 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 my child's medical file 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 my child, 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 my child 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 my child to the network will be carried out within 30 days of submission of the application to the HMO (kupat cholim).

Parent's Name: ____________________ Signature: ____________ Date: ______________

Parent's Name: ____________________ Signature: ____________ Date: ______________

Telephone number for clarifications (not compulsory): ________________________________

Email address for clarifications (not compulsory):____________________@_________________

I, the undersigned ______________________________ Position: ______________________

Branch:__________________________________ District: __________________________

Version 1.00 December 2013

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certify that ______________ ________________ ID No. ☐☐☐☐☐☐☐☐-☐
Given Name Surname

and that__________ __________________ ID No. ☐☐☐☐☐☐☐☐-☐
Given Name Surname

the parents of:

__________ __________________ ID No. ☐☐☐☐☐☐☐☐-☐
Given Name Surname

appeared before me and identified themselves using an identity document, and signed this form in my presence.

Name: ____________________ Signature: ______________ Date: ______________