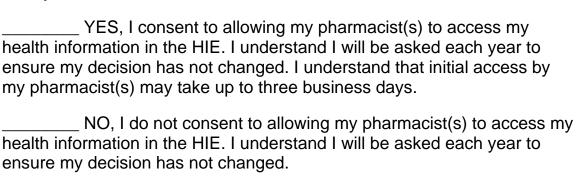


## CRISP Consent Form for Pharmacist Access to Medical Information at Independent Drug: 28 Kingston Rd. Baltimore, MD 21220

Your pharmacist at *Independent Drug* is dedicated to providing you with the best care. Having the ability to review your medical records from other provider locations, like hospitals and labs, can help your pharmacist provide this care. Health information exchange (HIE) is a way of sharing health information among participating doctors' offices, hospitals, labs, radiology centers, and other health care providers through secure, electronic means. HIE allows delivery of the right health information to the right place at the right time, providing safer, more timely, efficient, patient-centered care. The HIE we would use is called the Chesapeake Regional Information System for Our Patients (CRISP). Your pharmacist will only access this information if you opt-in.

By checking **Yes** below on this consent form, you are deciding to ALLOW your pharmacist(s) you interact with at this pharmacy to access your medical information available within the HIE. Your health care information cannot be accessed by your pharmacist(s) unless you sign this consent. By checking **No**, you will not allow access by any pharmacists at this pharmacy. You can also choose not to complete this form at all in which case your data will not be accessed.



If NO, you can choose to opt-out of the entire HIE by visiting <a href="http://crisphealth.org/FOR-PATIENTS/">http://crisphealth.org/FOR-PATIENTS/</a> and completing the online opt-out form. When you opt out of participation in the HIE, doctors and nurses will not be able to search for your health information through the HIE to use while treating you.

You can change your mind at any point in the future by simply filling out



another form or by calling or emailing CRISP directly via email at **info@crisphealth.org** or phone at **877-952-74477**. Your consent decision above applies only to this pharmacy location. Please provide the following information so we may proceed with your decision indicated above:

Name:		Date of
Birth:/	_/ Street Address:	
City:		
		State:
Zip:	Phone:	
Email:		
Signature:		Date:
complete the follow	d by a personal representative on ving:Personal Representative's Naividual (please print):	
For Pharmacy Us	se only	
CRISP ID#:	Urgent need: ☐ Yes Cor	nments:

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