

Sliding Fee Discount Application

Community Health Connection **DOES NOT OFFER FREE SERVICES**. However, patients may apply for the Sliding Fee Discount Program. Those who qualify will be offered a discount that is based on the GROSS income of ALL members of the household. To apply for this discount, patients **must** complete the following information **and** provide copies of the following documents:

- Proof of Income (choose one of the following):
 - Two most recent check stubs (within 30 days) **or**
 - Unearned income (Veteran's/ Military benefits, Social Security benefits, SSI, SSA, Child Support, etc.) **or**
 - Letter from employer, on company letterhead, indicating gross income and frequency of pay **or**
 - Notarized letter from employer indicating gross income and frequency of pay **or**
 - Most recent tax return (Forms 1040,1040-EZ, or 1040-A) if self-employed or if no other verification of income is available.
- Proof of Address (i.e. utility bill) (Responsible party if pediatric patient)
- All patients/responsible party must have photo identification

All patients will be responsible for the full cost of services provided unless the required documents (listed above) are presented with the completed application.

The Sliding Fee Discount Program expires after one year.

Patient/Responsible Party Name (please print): _____

Patient's Date of Birth: _____

Patient/Responsible Party Telephone Number: _____

Street address, City, State, Zip Code: _____

Current Employer (Name & telephone number): _____

Please list all household members below (including yourself):

Name	Date of Birth	Income/Frequency



By submitting this application and signing below you are certifying that:

- Information provided by you in this Sliding Fee Discount Application is true and correct.
- Payment is required on the date of service. You are required to pay an estimate of your portion of the Practitioner Visit and/or anticipated labs prior to being seen. If there are additional services, labs and/or procedures performed during your visit, you will be asked to pay for those at your time of departure.
- If for any reason you are unable to pay for your entire visit, payment arrangements may be available. Let the Front Desk staff know who will refer you to the Patient Account Specialist to discuss your options.
- You understand that eligibility in the Sliding Fee Discount Program is valid for one year.
- You are obligated to notify CHC of any changes in your income or household status.

Patient or Responsible Person's Signature

Date

BELOW TO BE COMPLETED BY FROND DESK STAFF ONLY

Gross Income listed above: _____ Daily Weekly Bi-Weekly Monthly Annually

Total Number of Dependents listed above: _____

Poverty Level: _____ (as calculated by eCW)

Assigned Sliding fee Schedule: _____ (as calculated by eCW)

Expiration Date: _____ Date Approved: _____

Reviewed and Approved (Front Desk Staff Initials): _____

Front Desk Staff:

- Verify that application is fully completed and signed by the patient.
- Complete "Office Use Only" section and indicate Poverty Level and Sliding Fee Category as calculated by eCW.
- Initial (legibly) and date for indicating you have reviewed document for completeness.
- Scan document into eCW
- Provide patient with completed and signed copy.



NEW PATIENT REGISTRATION FORM**General Information (Please Print)**

Date	Name (Last, First, Middle)		Date of Birth (Month/Day/Year)	
Other Names/Maiden Name/Also Know As (Last, First, Middle)			Social Security Number	
Gender Assigned at Birth <input type="radio"/> Male <input type="radio"/> Female	Please indicate the gender you most closely identify with <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Transgender Man/Transgender Male/Transmasculine <input type="radio"/> Transgender Woman/Transgender Female/Transfeminine <input type="radio"/> Other <input type="radio"/> Declined to Specify		Please Indicate your Sexual Orientation <input type="radio"/> Lesbian/Gay <input type="radio"/> Straight <input type="radio"/> Bisexual <input type="radio"/> Don't Know <input type="radio"/> Something Else <input type="radio"/> Declined to Specify	
Marital Status <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Widowed <input type="radio"/> Divorced	Ethnicity <input type="radio"/> Not Hispanic or Latino(a) <input type="radio"/> Chicano(a) <input type="radio"/> Cuban <input type="radio"/> Mexican <input type="radio"/> Mexican American <input type="radio"/> Puerto Rican <input type="radio"/> Another Hispanic, Latino(a), Spanish Origin; <i>Please specify</i> _____ <input type="radio"/> Declined to Specify			
Race (Please Check all that Apply) <input type="radio"/> White <input type="radio"/> Black or African American <input type="radio"/> American Indian/Alaska Native <input type="radio"/> Asian Indian <input type="radio"/> Chinese <input type="radio"/> Filipino <input type="radio"/> Japanese <input type="radio"/> Korean <input type="radio"/> Vietnamese <input type="radio"/> Other Asian; <i>If Other Asian, please specify</i> _____ <input type="radio"/> Native Hawaiian <input type="radio"/> Other Pacific Islander <input type="radio"/> Guamanian or Chamorro Samoan <input type="radio"/> Declined to Specify				
Home Address				Apt.
City	State	Zip Code	Are you Homeless? <input type="radio"/> Yes <input type="radio"/> No	If yes, please select one of the following: <input type="radio"/> Homeless <input type="radio"/> Transitional Living <input type="radio"/> Shelter
Work Phone Number	Home/Cell Phone Number <input type="radio"/> Home <input type="radio"/> Cell		Email Address	
Preferred Contact Method <input type="radio"/> Phone <input type="radio"/> Email <input type="radio"/> Mail	Are you an Active Military Member? <input type="radio"/> Yes <input type="radio"/> No	Are you a Veteran? <input type="radio"/> Yes <input type="radio"/> No	Employment <input type="radio"/> Full-time <input type="radio"/> Part-time <input type="radio"/> Seasonal <input type="radio"/> Migrant <input type="radio"/> Unemployed <input type="radio"/> Retired	
Employer		Occupation		
Employer Address		City	State	Zip Code
Annual Income*	Number of People in Household*	<i>*This information is used for Federal grant reporting purposes only and will not affect what we charge for your visit.</i>		
How did you hear about Community Health Connection? <input type="radio"/> Family/Friend <input type="radio"/> Health Fair/Event/Outreach <input type="radio"/> Newspaper/Magazine <input type="radio"/> Radio <input type="radio"/> TV <input type="radio"/> Website/Social Media <input type="radio"/> Other Advertising <input type="radio"/> Referral from another Provider		Do you or any members of your household have a relationship with Union Public Schools? <input type="radio"/> Yes <input type="radio"/> No		

Emergency Contact Information

Emergency Contact Name	Relationship to Patient		
Home Phone Number	Work Phone Number	Cell Phone Number	

Insurance Information (Primary)

Insurance Company Name/Medicaid/Medicare	Address			
City	State	Zip Code	Phone Number	
Effective/Issue Date	Group Number	Member Number/Claim Number	Patients Relationship to Subscriber	
Subscriber's Name		Subscriber's Employer		

Insurance Information (Secondary)

Insurance Company Name/Medicaid/Medicare	Address			
City	State	Zip Code	Phone Number	
Effective/Issue Date	Group Number	Member Number/Claim Number	Patients Relationship to Subscriber	
Subscriber's Name		Subscriber's Employer		



Dental Medical History

Last Name		First Name		Middle Name	Today's Date	Social Security Number
Date of Birth	Height	Weight	Phone Number		Work Phone	

For the following questions, check YES or NO, whichever applies. Your answers are for our records only and will be considered confidential.

Are you in good health?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Has there been any change in your general health within the past year?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are you now under the care of a physician?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Your physician's name, address and phone number: _____	

Have you had any serious illnesses or operations?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, what is the illness or operation? _____	

Do you have, or have you had any of the following diseases or problems?	
Damaged heart valves or artificial heart valves, including heart murmurs	<input type="checkbox"/> YES <input type="checkbox"/> NO
Congenital heart lesions	<input type="checkbox"/> YES <input type="checkbox"/> NO
Cardiovascular disease, heart trouble, heart attack, coronary insufficiency?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Coronary occlusion, high blood pressure, arteriosclerosis, stress?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are you ever short of breath after mild exercise?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have a cardiac pacemaker?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Allergies?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Sinus trouble?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Asthma or hay fever?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Hives or skin rash?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Fainting spells, seizures or epilepsy?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Diabetes?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Does your mouth frequently become dry?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Hepatitis, jaundice or liver disease?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Arthritis or inflammatory rheumatism (painful swollen joints)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Kidney trouble?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Tuberculosis?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have a persistent cough or cough up blood?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Low blood pressure?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Sexually transmitted diseases (Gonorrhea, Syphilis, Genital Herpes)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Psychiatric problems?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Cancer or Leukemia?	<input type="checkbox"/> YES <input type="checkbox"/> NO
AIDS or other immunosuppressive disorder?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Other:	
Have you had abnormal bleeding associated with previous extractions, surgery or trauma?	
	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you bruise easily?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you required a blood transfusion?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, please explain: _____	



NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

Last Review/Revision Date: 11/2024

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

If you have any questions about this notice, please contact Community Health Connection's (CHC's) Privacy Official at (918) 622-0641.

OUR PLEDGE REGARDING YOUR HEALTH INFORMATION

We understand that health information about you and your healthcare is personal. We are committed to protecting health information about you. We will create a record of the care and services you receive from us. We do so to provide you with the quality care and to comply with any legal or regulatory requirements. This Notice applies to all of the records generated or received by CHC, whether we documented the health information, or another doctor forwarded it to us.

This Notice will tell you the ways in which we may use or disclose health information about you. This Notice also describes your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

Our pledge regarding your health information is supported by Federal law. The privacy and security provisions of the Health Insurance Portability and Accountability Act ("HIPAA"), as amended by the Health Information Technology for Economic and Clinical Health Act ("HITECH Act") require us to:

- Make sure that health information that identifies you is kept private;
- Make available this notice of our legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the notice that is currently in effect.

Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously specified.

Right to an Accounting of Disclosures

You have the right to request a list (accounting) of any disclosures of your health information we have made, except for uses and disclosures (i) for treatment, payment, and health care operations, (ii) to individuals of protected health information about them, (iii) incident to a use or disclosure otherwise permitted or required by this law, (iv) pursuant to an authorization signed by you, (v) for the facility's directory or to persons involved in your care, (vi) for national security or intelligence purposes, (vii) to correctional institutions or law enforcement officials.

To request this list of disclosures, you must submit your request on a form that we will provide to you. Your request must state a time period that may not be longer than six (6) years prior to the date on which the accounting is requested. The first list of disclosures you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. We will mail you a list of disclosures in paper form within sixty (60) days of your request, or notify you if we are unable to supply the list within that time period and by what date we can supply the list; but this date should not exceed a total of ninety (90) days from the date you made the request.

Right to Request Restrictions

You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care. For example, you could ask that access to your health information be denied to a particular member of our workforce who is known to you personally.

While we will try to accommodate your request for restrictions, we are not required to do so if it is not feasible for us to ensure our compliance with law or we believe it will negatively impact the care we may provide you. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or you agree to terminate the restriction. To request a restriction, you must make your request on a form that we will provide you. In your request, you must tell us what information you want to limit and to whom you want the limits to apply.



Right to Request Confidential Communications

You have the right to request that we communicate with you about health matters in a certain manner or at a certain location. For example, you can ask that we only contact you at work or by mail to a post office box. During our intake process, we will ask you how you wish to receive communications about your health care or for any other instructions on notifying you about your health information and you agree to provide information as to how payment will be handled and specify an alternative address or other method of contact. We will accommodate all reasonable requests, provided that you have supplied information to us as to how payment will be handled and you have specified an alternative address or other method of contact.

Right to a Paper copy of This Notice

You have the right to obtain a paper copy of this Notice at any time upon request. You may also obtain a copy of this Notice on our web site (www.communityhealthconnection.org).

SPECIAL SITUATIONS

Minors and Persons with Guardians

Minors have all the rights outlined in this Notice with respect to health information relating to reproductive health care, except in emergency situations or when the law requires reporting of abuse and neglect. If you are a minor or a person with a guardian obtaining health-care that is not related to reproductive health, your parent or legal guardian may have the right to access your medical record and make decisions regarding the uses and disclosures of your health information.

Military and Veterans

If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation

We may release medical information about you to comply with laws relating to workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks

We may disclose medical information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths or conduct public health investigations;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- for health oversight activities;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Lawsuits and Disputes

We may disclose medical information about you in the course of any judicial or administrative proceeding in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process if we (i) have received assurance that the party seeking the information has made reasonable efforts to give you notice of the request and you have not objected or the party seeking the information has secured a qualified protective order, or (ii) have made reasonable efforts to provide notice of the request to you or have sought a qualified protective order.

Law Enforcement

We may release medical information if asked to do so by a law enforcement official:

- As required by law;
- In response to a court order, subpoena, warrant, summons, or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, the individual agrees or we are unable to obtain the person's agreement because of incapacity or emergency;



- About a death we believe may be the result of criminal conduct;
- In an instance of criminal conduct at our facility; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.

Coroners, Health Examiners and Funeral Directors

We may release health information to a coroner or health examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary to carry out their duties.

Inmates

If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary: (1) for the institution to provide you with healthcare; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy

You have certain rights to inspect and copy health information about you that may be used to make decisions about your care. Usually, this includes health and billing records and is information contained in a designated record set. This does not include psychotherapy notes, information compiled in anticipation of or use in a civil, criminal or administration action or proceeding, or information that is subject to or exempt from the Clinical Laboratory Improvements Amendment of 1988.

To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing on a form provided by us to: "The Privacy Official at CHC" at the address provided on the first page of this Notice. If you request a copy of your health information, we may charge a fee for the costs of copying (including supplies for and labor of copying), mailing, and preparing an explanation or summary of the health information (if you have requested such a summary and have agreed to such cost). We may deny your request to inspect and copy in limited circumstances. If you are denied access to health information, in certain instances you may request that the denial be reviewed. In instances where you may request that the denial be reviewed, another licensed healthcare professional chosen by our practice will review your request and the denial. The person conducting the review will not be the person who denied your initial request. We will comply with the outcome of the review.

Right to Amend

If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the information. To request an amendment, your request must be made in writing on a form provided by us and submitted to: "The Privacy Official at CHC."

We may deny your request for an amendment if it is not the form provided by us and does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information kept by or for our practice;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we may use or disclose health information about you. Unless otherwise noted each of these uses and disclosures may be made without your permission. For each category of use or disclosure, we will explain what we mean and give some examples. Not every use or disclosure in a category will be listed. However, unless we ask for a separate authorization all of the ways we are permitted to use and disclose information will fall within one of the categories.



For Treatment

We may use health information about you to provide you with healthcare treatment and services. We may disclose health information about you to doctors, nurses, technicians, health students, volunteers or other personnel who are involved in taking care of you. They may work at our offices, at a hospital if you are hospitalized under our supervision, or at another doctor's office, lab, pharmacy, or other healthcare provider to whom we may refer you for consultation, to take x-rays, to perform lab tests, to have prescriptions filled, or for other treatment purposes. For example, a doctor treating you may need to know if you have diabetes, because diabetes may slow the healing process. We may provide that information to a physician treating you at another institution.

Additionally, CHC may participate in an electronic health information exchange with other healthcare provider members, in which we send patient data to a network system committed to securing the information and allowing your data to be available to another member who is providing treatment to you. You may choose to not participate in, or 'opt out,' of this electronic health information exchange at any time.

For Payment

We may use and disclose health information about you so that the treatment and services you receive from us may be billed to and payment collected from you, an insurance company, and a state Medicaid agency or a third party. For example, we may need to give your health insurance plan information about your office visit so your health plan will pay us or reimburse you for the visit. Alternatively, we may need to give your health information to the state Medicaid agency so that we may be reimbursed for providing services to you. In some instances, we may need to tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Healthcare Operations

We may use and disclose health information about you for operations of our healthcare practice. These uses and disclosures are necessary to run our practice and make sure that all of our patients receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, whether certain new treatments are effective, or to compare how we are doing with others and to see where we can make improvements. We may remove information that identifies you from this set of health information so others may use it to study healthcare delivery without learning who our specific patients are.

Appointment Reminders

We may use and disclose health information to contact you as a reminder that you have an appointment. Please let us know if you do not wish to have us contact you concerning your appointment, or if you wish to have us use a different telephone number or address to contact you for this purpose.

Fundraising Activities

We may use health information about you to contact you in an effort to raise money for our not-for-profit operations. Please let us know if you do not want us to contact you for such fundraising efforts.

Research

There may be situations where we want to use and disclose health information about you for research purposes. For example, a research project may involve comparing the efficacy of one medication over another. For any research project that uses your health information, we will either obtain an authorization from you or ask an Institutional Review or Privacy Board to waive the requirement to obtain authorization. A waiver of authorization will be based upon assurances from a review board that the researchers will adequately protect your health information.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in our facility and on our website and you may request a paper copy of the Notice. The Notice contains the effective date at the bottom of each page.



COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us and with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact: "The Privacy Official at CHC" at the address on the first page of this Notice. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain the records of the care that we provided to you.



A PATIENT'S GUIDE TO MYHEALTH

WE ARE USING INFORMATION TECHNOLOGY TO HELP YOU As Community Health Connection, Inc. (CHC) keeps pace with advancements in health care, we have a growing need to safely and efficiently use computers to electronically share your health information with the team of health professionals who provide care to you.

Currently, when we need to share your health information with other health providers the process is difficult and usually means numerous phone calls, mailings and faxes. And, when we need to gather information from one of your other providers it can take hours or even weeks and sometimes the information is not available at all. Technology can help us do better.



MEET OUR NEW PARTNER, MYHEALTH ACCESS NETWORK.

MyHealth Access Network (MyHealth) is a non-profit coalition of Oklahoma health providers, including doctors, hospitals, labs, pharmacies, emergency services and other health industry professionals, who are using technology to link medical providers, exchange timely information and improve the delivery of local health care. MyHealth allows us to deliver the right information to the right doctor, at the right time, to help care for you.

FREQUENTLY ASKED QUESTIONS

Although MyHealth is designed to be used by health care professionals, it provides many important benefits and choices for you. We've attempted to answer the most common questions here:

WHO CAN ACCESS MY INFORMATION?

Only the health industry professionals involved in your care (and their approved staff members) that belong to the MyHealth network can access your information, and only as their jobs require it.

WHAT ARE SOME EXAMPLES OF HOW MyHealth HELPS ME?

Time is important when addressing your health needs. Some examples of when and how your personal health information is used to help you include:

- When you see a medical specialist, your doctor and the specialist need to share your information to help coordinate effective care. The quicker this happens, the quicker you receive the care you need.
- In a medical emergency such as a car accident, ambulance and emergency room doctors can have access to important health information that might save your life or that of a loved one; like a medication list, drug and food allergies, presence of a pacemaker, etc.
- If you manage care for yourself, a child, parent, etc., then you know the challenges of keeping up with medication lists, procedures, allergies, and vaccinations. MyHealth can help make these available in the doctor's office.

WHAT HEALTH INFORMATION IS STORED IN MYHEALTH ACCESS NETWORK?

Only high priority health information is included in MyHealth Access Network. This includes:

- Names of the doctors and other health professionals who provide your care.
- Past procedures
- Known allergies
- Immunization records
- Basic personal information (name, address, contact information, etc.)
- Diagnoses
- Current prescribed medications
- Lab and x-ray results



HOW DOES MY INFORMATION STAY SECURE?

We take your privacy very seriously, and information shared through MyHealth is protected with the highest forms of security, including encryption and secured connections. We know that patients must trust their information is safe. MyHealth complies with all State and Federal laws (like HIPAA) to protect your information.

DO I NEED TO SIGN UP FOR THIS SERVICE?

No. Because CHC is a participating MyHealth partner you are included in the network. You may opt out if you wish (see how below).

CAN I CHOOSE NOT TO PARTICIPATE IN MYHEALTH?

Yes, you can choose to not participate in, or 'opt out' of MyHealth at any time. Choosing to opt out generally means that your doctors will not be able to use the MyHealth network to electronically access your health information. You can opt out of MyHealth by:

1. Obtaining an Opt Out of MyHealth Form from our front desk clerk, or by downloading the form from www.myhealthaccess.net/opt-out
2. Complete the form (please wait to sign it in front of our desk clerk)
3. Bring the form to our front desk clerk and sign it with our clerk as a witness. We will send it to MyHealth for you OR you may sign your form with a Notary Public as a witness and mail it to the address provided on the form.

You can always return to MyHealth by completing the Return to MyHealth Form which is also available from our front desk clerk, or online at www.myhealthaccess.net/opt-in

WHO IS MYHEALTH ACCESS NETWORK?

MyHealth is an Oklahoma non-profit organization created by patients, doctors, hospitals, emergency responders, insurance plans, and other organizations providing health care to Oklahomans. To learn more about MyHealth, visit www.myhealthaccess.net.

WHO DO I CONTACT FOR MORE INFORMATION OR SUPPORT?

If you would like more information about MyHealth, please visit: www.myhealthaccess.net or call 918-236-3451.

