HEALTH INFORMATION EXCHANGE (HIE) OF REFERRAL DATA TO THE CALIFORNIA SMOKERS' HELPLINE (CSH)

REGISTRATION FOR INTENT TO USE HIE FOR ELECTRONIC TRANSFER OF PATIENT DATA TO THE CSH

INSTRUCTIONS: This form is for agencies to register their intent of meeting the Specialized Registry Reporting measure via health information exchange with CSH. Additionally, this form establishes a relationship with the State of California, Department of Public Health, California Tobacco Control Program (CTCP) for the purpose of HIE. It is to be used to keep CTCP informed of data transmission preferences and communication contacts. Health Practice Management firms and Physician/Medical groups must be given patient consent to transmit personal data to the CSH.

PLEASE EMAIL COMPLETED FORM TO CTCPinbox@cdph.ca.gov

AGENCY TYPE

CHOOSE YOUR AGENCY TYPE:	☐ HOSPITAL	☐ HEALTH PRACTICE MANAGEMENT FIRM	☐ MEDICAL or PHYSICIANS GROUP	NPI #: *(not applicable for Health Practice Management firms)*
AGENCY NAME		STREET ADDRESS		
CITY			STATE	ZIP

DATA TRANSMISSION REFERENCE

HOW WOULD YOU LIKE TO EXCHANGE DATA?	☐ ONC DIRECT	☐ HL7 via TCP/IP	☐ OTHER	Data Standard (CCD, HL7 2.x, etc):	☐ DON'T' KNOW

PRIMARY CONTACT FOR HIE COMMUNICATION

FIRST NAME	LAST NAME	TITLE		REPLACES CURRENT PRIMARY CONACT ☐
STREET ADDRESS	CITY	STATE	ZIP	
TELEPHONE NUMBER (With area code)	EXTENSION	EMAIL ADDRESS	EFFECTIVE DATE:	

PLEASE PROVIDE AT LEAST ONE ADDITIONAL HIE CONTACT

CONTACT 1	FIRST NAME	LAST NAME	TITLE		☐ ADD ☐ REMOVE
	STREET ADDRESS	CITY	STATE	ZIP	
	TELEPHONE NUMBER (With area code)	EXTENSION	EMAIL ADDRESS	EFFECTIVE DATE:	
CONTACT 2	FIRST NAME	LAST NAME	TITLE		☐ ADD ☐ REMOVE
	STREET ADDRESS	CITY	STATE	ZIP	
	TELEPHONE NUMBER (With area code)	EXTENSION	EMAIL ADDRESS	EFFECTIVE DATE:	

AUTHORIZATION AND APPROVAL

THE UNDERSIGNED HEREBY AUTHORIZES HIE EXCHANGE ON BEHALF OF ALL CONSENTING PROVIDERS

NAME PRINTED	SIGNATURE	DATE SIGNED (MM/DD/YYYY)

You may submit clinician information on a spreadsheet accompanying this form.

CLINICIANS WHO HAVE GIVEN CONSENT FOR YOUR AGENCY TO RECEIVE THEIR HIE

CLINICIAN 1

FIRST NAME			LAST NAME		CLINICIAN TYPE: PHYSICIAN ☐ MIDWIFE ☐
FACULTY NAME			TELEPHONE NUMBER (With area code)	EXTENSION	STATUS CHANGE: ADD ☐ REMOVE ☐
STREET ADDRESS			EMAIL ADDRESS		EFFECTIVE DATE:
CITY	STATE	ZIP	LICENSE #		NPI #

CLINICIAN 2

FIRST NAME			LAST NAME		CLINICIAN TYPE: PHYSICIAN ☐ MIDWIFE ☐
FACULTY NAME			TELEPHONE NUMBER (With area code)	EXTENSION	STATUS CHANGE: ADD ☐ REMOVE ☐
STREET ADDRESS			EMAIL ADDRESS		EFFECTIVE DATE:
CITY	STATE	ZIP	LICENSE #		NPI #

CLINICIAN 3

FIRST NAME			LAST NAME		CLINICIAN TYPE: PHYSICIAN ☐ MIDWIFE ☐
FACULTY NAME			TELEPHONE NUMBER (With area code)	EXTENSION	STATUS CHANGE: ADD ☐ REMOVE ☐
STREET ADDRESS			EMAIL ADDRESS		EFFECTIVE DATE:
CITY	STATE	ZIP	LICENSE #		NPI #

CLINICIAN 4

FIRST NAME			LAST NAME		CLINICIAN TYPE: PHYSICIAN ☐ MIDWIFE ☐
FACULTY NAME			TELEPHONE NUMBER (With area code)	EXTENSION	STATUS CHANGE: ADD ☐ REMOVE ☐
STREET ADDRESS			EMAIL ADDRESS		EFFECTIVE DATE:
CITY	STATE	ZIP	LICENSE #		NPI #

CLINICIAN 5

FIRST NAME			LAST NAME		CLINICIAN TYPE: PHYSICIAN ☐ MIDWIFE ☐
FACULTY NAME			TELEPHONE NUMBER (With area code)	EXTENSION	STATUS CHANGE: ADD ☐ REMOVE ☐
STREET ADDRESS			EMAIL ADDRESS		EFFECTIVE DATE:
CITY	STATE	ZIP	LICENSE #		NPI #