



San Antonio A thru Z Pediatrics, P.A.
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Acknowledgement to Share Information with a Health Information Exchange

San Antonio A thru Z Pediatrics, P.A. ["A thru Z"] participates in Healthcare Access San Antonio (HASA) which is a nonprofit, community health information exchange that facilitates electronic exchange of patient information with physicians, hospitals, labs, pharmacies and other providers. HASA will also connect to other HIEs to allow information to be available to other providers when patients travel outside of our region. Sharing patient information with other providers through HASA helps A thru Z save patients' time and make better treatment decisions with a more complete patient record. It will allow them to avoid duplicate tests and procedures and gain immediate access in emergencies to critical information like allergies, diagnosis, medications and other important data. Patients read more about HASA at www.hasatx.org for more information about how HASA helps us promote patient health and protects patient information.

I understand that A thru Z shares patient information through HASA and have received a copy of HASA's brochure.

Initials _____

Patients have the right to opt out of having their information shared through HASA by signing an Opt-Out Form. You may request an Opt Out form from A thru Z staff and they will help you complete it. A thru Z will not discriminate against you if you choose to sign an Opt Out form and A thru Z does not require you to share information through HASA in order to receive medical treatment.

I understand that I have the right to Opt Out of having my patient information shared through HASA by signing an Opt Out Form.

Initials _____

HASA makes every effort to ensure that sensitive patient information, such as HIV/AIDS, mental health, and substance abuse treatment related information (sensitive information), is blocked from viewing. However, due to system limitations, A thru Z and HASA are limited in blocking sensitive information at this time. By initialing this paragraph and signing this form you are agreeing to share your sensitive information with other providers through HASA.

I agree to share my sensitive information with other providers through HASA.

Initials _____

Signed this _____ day of _____, _____

Signature of Parent or Guardian