REQUEST FOR ACCESS, EXCHANGE, OR USE OF USCDI DATA SETS UNDER THE INFORMATION BLOCKING RULE

Date: ______________________

To: MIDLAND HEALTH
INFORMATION BLOCKING STEERING COMMITTEE
Email: Infoblock@midlandhealth.org

Requestor:
Address:
Telephone #:
Email:

PURPOSE FOR REQUEST

◯ **Access:** Request for electronic access to the specified data sets below.

◯ **Exchange:** Request for Midland Health to electronically transmit the specified data sets below with another technology, system, platform, or network.

◯ **Use:** Request for electronic use of the specified data sets below. **[Use of EPHI for research or innovation purposes]**

LIST OF USCDI DATA SETS

◯ **Allergies and Intolerances**
- Substance (Medication)
- Substance (Drug Class)
- Substance (Non-Medication)
- Reaction

◯ **Clinical Notes**
- Consultation Notes
- Discharge Summary Note
- History & Physical
- Procedure Note
- Progress Note

◯ **Diagnostic Imaging**
- Diagnostic Imaging Test
- Diagnostic Imaging Report

◯ **Care Team Member(s)**
- Member Name
- Member Identifier
- Member Role
- Member Location
- Member Telecom

◯ **Clinical Tests**
- Clinical Test Result/Report

◯ **Encounter Information**
- Encounter Type
- Encounter Diagnosis
- Encounter Time
- Encounter Location
- Encounter Disposition
- Encounter Identifier

◯ **Facility Information**
- Facility Name
- Facility Identifier
- Facility Type

◯ **Health Insurance Information**
- Coverage Status
- Coverage Type
- Relationship to Subscriber
- Member Identifier
- Subscriber Identifier
- Group Identifier
- Payer Identifier

◯ **Immunizations**
- Immunizations

◯ **Laboratory**
- Tests
- Values/Results
- Specimen Type
- Result Status
- Specimen Source Site
- Result Interpretation
- Specimen Identifier
- Specimen Condition and Disposition
- Result Reference Range
- Result Unit of Measure

◯ **Patient Demographics/Information**
- First Name
- Last Name
- Middle Name (including middle initial)
- Name Suffix
- Previous Name
- Date of Birth
- Date of Death
- Race
- Ethnicity
- Tribal Affiliation
- Sex
- Sexual Orientation
- Gender Identity
- Preferred Language
- Current Address

◯ **Goals**
- Patient Goals
- SDOH Goals
- Treatment Intervention Preference
- Care Experience Preference

◯ **Health Status Assessments**
- SDOH Assessment
- Health Concerns
- Functional Status
- Disability Status
- Mental/Cognitive Status
- Pregnancy Status
- Smoking Status
- Substance Use
- Alcohol Use
- Physical Activity

◯ **Medical Devices**
- Unique Device Identifier – Implantable

◯ **Medications**
- Medications
- Dose
- Dose Unit of Measure
- Indication
- Fill Status
- Medication Instructions
- Medication Adherence

◯ **Patient Summary and Plan**
- Assessment and Plan of Treatment

◯ **Problems**
- Problems
- Problems/Health Concerns
- Date of Diagnosis
- Date of Resolution

◯ **Procedures**
- Procedures
- SDOH Interventions
- Reason for Referral
- Time of Procedure

Previous Address
Phone Number

◯ **Patient Demographics/Information (Continued)**
Phone Number Type
Email Address
Related Person's Name
Relationship Type
Occupation
Occupation Industry

◯ **Vital Signs**
Systolic Blood Pressure
Diastolic Blood Pressure
Average Blood Pressure
Heart Rate
Respiratory Rate
Body Temperature
Body Height
Body Weight
Pulse Oximetry
Inhaled Oxygen Concentration
BMI Percentile (2 – 20 years)
Weight-for-length Percentile (Birth – 24 Months)
Head Occipital-frontal Circumference Percentile (Birth – 36 Months)

◯ **Provenance**
Author Time Stamp
Author Organization

Signature Authorization: I have read this form and agree to the uses and disclosures of the information. I understand that Midland Health will assess the eight (8) exceptions within the Information Blocking Rule under the Cares Act and will determine if this request can be accommodated. I also understand that Midland Health will provide a response to this request within ten (10) business days from the receipt of the request.

Signature X ____
Signature of Individual or Individual's Legally Authorized Representative

Date: ________________________