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 MEDICAL or PHYSICIANS						NPI #: (not applicable for Hea	alth Practice Management firms)				
	MAN	NAGEMENT FIRM	MEDICAL								
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CITY						STATE	ZIP				
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DATA TRANSMISSION REFERENCE HOW WOULD YOU LIKE TO EXCHANGE Data Standard (CCD, HL7 2.x, etc):											
DATA? ONC DIRECT HL7 via TCP/IP OTHER DON'T' KNOW											
		PRIMARY CON	TACT FOR	HIE COM	MUNICATION	ON					
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AUTHORIZATION AND APPROVAL											
THE UNDERSIGNED HEREBY AUTHORIZES HIE EXCHANGE ON BEHALF OF ALL CONSENTING PROVIDERS											
NAM	E PRINTED	SIGNATURE			DATE SIGNED (MM/DD/YYYY)						
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California Department of Public Health ● California Tobacco Control Program ● MS 7206, P.O. BOX 997377 ● Sacramento, CA 95899-737											
Website: www.edph.ca.gov/programs/tohacco/Dagoc/default.acpy. • E. mail: CTCDinhay@edph.ca.gov. • DHONE: 015/440 E500											
vveb	Website: www.cdph.ca.gov/programs/tobacco/Pages/default.aspx • E-mail: CTCPinbox@cdph.ca.gov • PHONE: 916/449-5500										

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

CLINICIANS WHO HAVE GIVEN CONSENT FOR YOUR AGENCY TO RECEIVE THEIR HIE										
	FIRST NAME			LAST NAME			CLINICIAN TYPE:			
							PHYSICIAN MIDWIFE			
CLINICIAN 1	FACULTY NAME			TELEPHONE NUMBER (With area code) EXTE		TENSION	STATUS CHANGE:			
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CLINICIAN 5							PHYSICIAN MIDWIFE			
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	STREET ADDRESS			EMAIL ADDRESS			EFFECTIVE DATE:			
•	CITY	STATE	ZIP	LICENSE #		NPI#				