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| Survey for Developing Educational Material for Sharing Patient Medical Information | | |
| What information do you need to decide whether health care providers may electronically share your medical information? | | |
| *As described in our cover letter, doctors and hospitals can electronically share patient health information through HEALTHeLINK, a health information exchange. HEALTHeLINK stores your health information and makes it available to HEALTHeLINK members (health care providers who are treating you) when they ask for it.*  *We are surveying 2,800 New York residents. Our survey asks about the information you need before deciding whether to allow your physicians to share your medical information through a health information exchange like HEALTHeLINK.*  *Your feedback is important. Please return this voluntary and anonymous survey in the stamped return envelope by XXXX DATE.* | | |
| Tell Us About Yourself | | |
| 1. Please circle your gender. | 1. Male B. Female | |
| 1. Do you speak a language other than English at home? | 1. Yes B. No | |
| 1. What is your age? |  | |
| 1. Please circle your highest level of completed education. | 1. Not a high school graduate 2. High school graduate 3. Some college but no degree | 1. Associate’s degree 2. Bachelor’s degree 3. Advanced degree |
| 1. Please circle the county you live in. | 1. Allegany 2. Cattaraugus 3. Chautauqua 4. Erie | 1. Genesee 2. Niagara 3. Orleans 4. Wyoming |
| Please tell us how you prefer to receive information and what information you need. Please circle your responses to the following statements. | | |
| 1. I would prefer to learn about my provider’s electronic sharing of my medical information through… (circle all that apply) | | |
| Brochure Health Care Provider Video/You Tube E-mail    Internet Website/Blog Mobile Device Other | | |
| Before I decide whether to allow providers to electronically share my medical information through a health information exchange, I would want to know… (please circle one choice per statement) | | |
| 1. … which of my health care providers (my doctor, my hospital, other providers) would share my medical information. | | |
| Strongly Disagree Disagree Neutral Agree Strongly Agree | | |
| 1. … whether my information will be shared with health insurance companies, Medicare, or Medicaid. | | |
| Strongly Disagree Disagree Neutral Agree Strongly Agree | | |
| 1. … whether sensitive information (such as genetic information, HIV test results or mental health care) will be shared. | | |
| Strongly Disagree Disagree Neutral Agree Strongly Agree | | |
| 1. … who can access my medical information (health care providers, health insurers). | | |
| Strongly Disagree Disagree Neutral Agree Strongly Agree | | |
| 1. ... how my information will be used by doctors, hospitals, labs, and other health care providers. | | |
| Strongly Disagree Disagree Neutral Agree Strongly Agree | | |
| 1. … how my information is kept safe from people who are not authorized to see it. | | |
| Strongly Disagree Disagree Neutral Agree Strongly Agree | | |
| 1. … how I can change my mind about my choice whether to share my information. | | |
| Strongly Disagree Disagree Neutral Agree Strongly Agree | | |
| 1. … what happens if someone misuses (gains access or shares without permission) my information. | | |
| Strongly Disagree Disagree Neutral Agree Strongly Agree | | |
| 1. … my legal rights regarding the electronic sharing of my information (individual privacy rights). | | |
| Strongly Disagree Disagree Neutral Agree Strongly Agree | | |
| 16. Please use the space below to tell us what other information you need before deciding whether to allow physicians to electronically share your medical information through a health information exchange. | | |
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| Thank you very much. Please mail your completed survey back to us in the enclosed envelope by XXXX DATE. | | |