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 gend	ler.	A. Male	B. Female		
2. Do you speak a language other than English at home?		A. Yes	B. No		
3. What is your age?					
4. Please circle your high education.	est level of completed	A. Not a high school graduateB. High school	D. Associate's degree E. Bachelor's degree		
	L L	graduate C. Some college but no degree	F. Advanced degree		
5. Please circle the county y	ty you live in.	A. Allegany	E. Genesee		
		B. Cattaraugus	F. Niagara		
		C. Chautauqua	G. Orleans		
		D. Erie	H. Wyoming		
Please tell us how you prefer to receive information and what information you need. Please circle your responses to the following statements.					
6. 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		

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0990-0376. The time required to complete this information collection is estimated to average five minutes per response, including the time to review instructions, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Health & Human Services, OS/OCIO/PRA, 200 Independence Ave., S.W., Suite 336-E, Washington D.C. 20201, Attention: PRA Reports Clearance Officer

Internet	Website/Bl	log	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)						
	ealth care providers (my doctor, my ho	spital, other provid	lers) would share my medical		
information.	Disatura	Nauturl	A due e	Church when A stress		
Strongly Disagree	_	Neutral	Agree	Strongly Agree		
			•	s, Medicare, or Medicaid.		
Strongly Disagree		Neutral	Agree	Strongly Agree		
9 whether sensitive information (such as genetic information, HIV test results or mental health care) will be shared.						
Strongly Disagree	e Disagree	Neutral	Agree	Strongly Agree		
10 who can access my medical information (health care providers, health insurers).						
Strongly Disagree	e Disagree	Neutral	Agree	Strongly Agree		
11 how my information will be used by doctors, hospitals, labs, and other health care providers.						
Strongly Disagree	e Disagree	Neutral	Agree	Strongly Agree		
12 how my information is kept safe from people who are not authorized to see it.						
Strongly Disagree	e Disagree	Neutral	Agree	Strongly Agree		
13 how I can change my mind about my choice whether to share my information.						
Strongly Disagree	e Disagree	Neutral	Agree	Strongly Agree		
14 what happens if someone misuses (gains access or shares without permission) my information.						
Strongly Disagree	e Disagree	Neutral	Agree	Strongly Agree		
15 my legal rights regarding the electronic sharing of my information (individual privacy rights).						
Strongly Disagree	e 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.						
Thank you very muc <u>DATE</u> .	h. Please mail your co	ompleted survey	back to us in the en	closed envelope by XXXX		