Health Information Exchange Patient Opt-Out Form

This form is to be used by patients who **do not** wish to participate in a Health Information Exchange (HIE).

A Health Information Exchange, or HIE, is a way of sharing your health information among participating doctors' offices, hospitals, labs, radiology centers, and other health care providers through secure, electronic means. The purpose is so that each of your participating providers can have the benefit of the most recent information available from your other participating caregivers when taking care of you. The Health Information Exchange helps your participating providers share information in a timely manner to more effectively coordinate your care. When you opt-out of participation in the HIE, doctors and nurses will not be able to search for your health information through the HIE to use while treating you. Instead, your providers will continue to share information through previously established methods, such as phone, fax, mail, or other electronic communications.

After considering my option of participating in the Health Information Exchange, I have decided to OPT-OUT and NOT participate in the HIE. By choosing to opt-out, I understand and agree to the following:

1. Opting out of the HIE may delay access to important medical information.

2. My health information will not be shared among health providers through the HIE. Instead my providers will continue to share my information via previously established methods, such as phone, fax, mail, or other electronic communications.

3. Any information that is shared before I submit this HIE Opt-Out Form may remain with providers who accessed information before this Opt-Out went into effect.

4. My HIE Opt-Out selection will remain in effect unless I complete a Cancellation of Health Information Exchange Patient Opt-Out Form.

5. This request can take up to 3-5 business days to take effect.

Name:_____ Date of Birth:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Phone: _____ Email:_____

If this form is signed by someone other than the person named above, the person signing the form certifies that he/she is acting as (Check One): ❑Parent ❑ Legal Guardian ❑Other (Specify Relationship) _____for the patient named above.

Printed Name:_____

Signature:_____ Date:_____