HEALTH INFORMATION EXCHANGE (HIE) OPT-OUT FORM

The Health Information Exchange (HIE) allows your medical information to be available and viewed electronically by doctors and your medical team members. The HIE is designed to provide quick access to medical records to make treatment more effective and efficient. Any authorized healthcare provider and their medical team who agree to participate in the HIE can electronically access and use your protected health information, if needed, to provide treatment to you.

Patient Information		
Last Name	First Name	Middle Name
Previous Name or Nickname	Date of Birth	Primary Phone Number
Address	City	State ZIP Code

I and/or my legally authorized representative have considered whether to allow my information to be viewed in the HIEs in which the Department of Health participates and have decided to ***OPT-OUT*** *and* ***NOT*** *allow information to be viewed in the HIEs in which the DOH participates.* A decision to complete the form will not have any effect on any benefits to which you may otherwise be entitled, however, you will not be able to participate in HIE.

By choosing to opt out of the HIEs, I hereby acknowledge and agree as follows:

» This revocation only applies to the sharing of health information through the HIE. Health care providers may still have access to my health information using other methods such as fax, telephone, or mail.

» By opting out of participation in the HIE, my healthcare providers outside of DOH will NOT be able to search for my DOH records through the HIE while providing me treatment.

» My HIE OPT-OUT election will remain in effect until I notify DOH, and sign a Revocation of HIE Opt-Out Request Form.

» This HIE OPT-OUT request may take up to seven (7) business days to take effect.

» Any information that is shared before I submit this HIE OPT-OUT form may remain with providers who accessed this information before this OPT-OUT went into effect.

If this form is signed by someone other than the person named above, the person signing this form certifies that they are acting as (check one) _____Parent, _____Legal Guardian, or _____ Healthcare Power of Attorney for the person named above.

Printed Name: _____ Signature: _____

Date: _____