Health Information Exchange (HIE) Opt-Out Form

This form is to be completed by patients who **DO NOT** wish to participate in Carilion Clinic's Health Information Exchange (HIE).

Patient's Full Name	*Date of Birth*
Street Address	*Phone (Home or Cell)*
City, State, Zip Code	*Primary Care Provider (optional)*
Email Address	

A Health Information Exchange, or HIE, is the secure electronic sharing of health information across other organizations. Exchanging information electronically is a faster way to share your health information with healthcare providers treating you. For example, if you go to a hospital emergency room that participates in the HIE, the emergency room physicians would be able to access your Carilion Clinic health information to help make treatment decisions for you.

Unless you opt out, any authorized non-Carilion Clinic healthcare provider who agrees to participate in the HIE can electronically access and use your Protected Health Information if needed to provide treatment to you.

If you opt out of participation in the HIE, your non-Carilion Clinic healthcare providers will NOT be able to search for your health information through the HIE to use while treating you. However, healthcare providers may still request and receive your medical information from other providers using other methods permitted by law, such as fax, mail, or other electronic communications.

I acknowledge and agree as follows:

- I request that my Carilion Clinic health information no longer be shared through the Health Information Exchange (HIE) to all non-Carilion Clinic healthcare providers involved in my care who participate in or are connected to the HIE;
- I understand that by making this selection, none of my non-Carilion Clinic healthcare providers will be able to electronically access my health information maintained by Carilion Clinic via HIE, even in cases of medical emergency;
- I understand that this Opt-Out request only applies to sharing my health information through the HIE system. I recognize that when I see a healthcare provider for treatment, that provider may request and receive my medical information using other methods provided by law, such as fax, telephone, email, or mail;

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- I understand that this HIE Opt-Out Request does NOT mean that I am opting out of all other healthcare organization HIEs. I understand that if I wish to opt out of another HIE, I must communicate with each of my healthcare providers participating in such other HIEs;
- I understand that any information that is disclosed before I submit this request cannot be taken back and will remain with the healthcare provider if the provider has access to such information;
- I understand that once this Opt-Out goes into effect, I can change my decision only by submitting a *Carilion Clinic HIE Reinstatement of Participation* form;
- This request to opt out can take up to 72 hours to take effect.

If this form is signed by someone other than the person named above, the person signing the form hereby certifies that he/she is acting as:

Choose one: ☐ Parent ☐ Legal Guardian ☐ Other *(please specify)* _____

Contact information for the individual completing this form if other than the patient.

_____ _____

Print Name *Phone Number*

_____ _____ _____

Signature of Patient or Patient's Legal Representative *Date* *Time*

_____

Relationship to Patient / Description of Authority to Act

Return completed form to any Carilion Clinic Medical Records department or mail/fax to:

Carilion Clinic
Attn: Medical Records
1906 Belleview Avenue
Roanoke, VA 24014

Fax: (540) 981-7868

Staff Use Only:

Received: _____

Completed: _____

Initials: _____

CARILION CLINIC

CMC - CRMH CMC - CRCH CFMH CGCH CNRV CRBH CTCH

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CHART-5099

PATIENT IDENTIFICATION