Health Information Exchange (HIE) Reinstatement of Participation Form

This form is to be completed by patients who previously elected to opt out of Carillon 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	

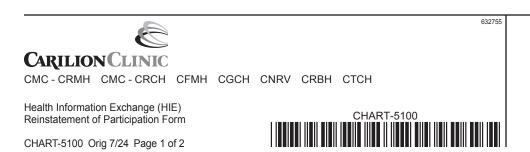
A Health Information Exchange, or HIE, is the secure electronic sharing of health information across other organizations. Exchanging information electronically is a faster way to share your health information with healthcare providers treating you. For example, if you go to a hospital emergency room 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. Your participation in the HIE is voluntary and subject to your right to opt out.

I previously submitted a request to opt out of the Carilion Clinic HIE system. I am now requesting to be reinstated so that my health information can be electronically accessible through the HIE to authorized healthcare providers.

I acknowledge and agree as follows:

- I wish to REVOKE (change) my prior decision to opt out of Carilion Clinic's HIE, and now I specifically authorize my information to be transmitted to Carilion Clinic's HIE to be electronically available to my external providers that participate in or are connected to the HIE.
- I understand that by making this selection now, ALL my authorized providers who participate in or are connected to the Carilion Clinic HIE will have access to my health information maintained in the Carilion Clinic HIE.
- I understand that this reinstatement can only be changed if I specifically submit a new opt-out request form.
- This request to reinstate can take up to 72 hours to take effect.

(continued)



PATIENT IDENTIFICATION

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above, the person signing the fo	orm hereby	
□ Other <i>(please specify)</i>		
ner than the patient.		
Phone Number		
Date	Time	
Staff Use Only: Received: Completed: Initials:		
	Phone Number Date Staff Use Only: Received: Completed:	

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CARILION CLIN	IC

Fax: (540) 981-7868

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