Health Information Exchange (HIE) Reinstatement of Participation Form

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

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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: _____

PATIENT IDENTIFICATION