capitalhealth

CANCELLATION OF PRIOR TRENTON HEALTH INFORMATION EXCHANGE OPT-OUT

Name: _____

Date of Birth: _____/_____ /_____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ e-mail: _____

I hereby acknowledge and agree as follows:

1. I WISH TO cancel my prior decision to Opt-Out of the Trenton HIE, and now I specifically AUTHORIZE my information maintained in the Trenton HIE to be electronically available to my providers;

2. I UNDERSTAND that by making this selection, now ALL of my authorized providers who participate in the Trenton HIE or are connected to the Trenton HIE will have access to my health information maintained in the Trenton HIE;

3. I UNDERSTAND that by making this selection, my health information may be accessible by other HIEs with whom the Trenton HIE participate.

4. I UNDERSTAND that this cancellation can only be changed if I specifically submit a new Trenton HIE Opt-Out form;

5. I have had an opportunity to have all my questions regarding this "Cancellation of Prior Trenton HIE Opt-Out" and others answered; and

6. This request can take 2-3 business days to take effect.

Signature: _____ Date: _____

If Legal Rep, state Authority: _____

Completed and signed Trenton HIE Opt-Out form can be sent to the Health Information Department at Capital Health.