# Capital Health

## Health Information Exchanges
## Patient Opt Out

Patient First Name _____
Patient Middle Name _____
Patient Last Name _____
Address Line 1 _____
Address Line 2 _____
City, State, Zip Code _____
Primary Phone Number _____
Secondary Phone Number _____
Email _____
Date of Birth _____
Sex (M/F) _____

I hereby acknowledge and agree as follows:

1. I WISH to OPT OUT of all of the Health Information Exchanges (HIE) in use at Capital Health, including but not limited to, CommonWell and the Trenton Health Information Exchange. I understand that by making this selection, none of my health care providers will be able to access my health information through the HIEs referenced above, even in cases of a medical emergency;
2. I UNDERSTAND that my providers who originally generated information about me will continue to have access to my information, but only in the medical record that they created for me, or by obtaining it via previously established methods;
3. I UNDERSTAND that this HIE Opt Out will NOT allow the HIEs referenced above to make my health information available to other connected HIEs, even in cases of a medical emergency;
4. I UNDERSTAND that this HIE Opt Out does NOT cover or effectuate my opting out of any other HIEs. I UNDERSTAND that if I wish to opt out of another HIE, I am responsible for approaching my provider participating in such other HIE(s) about how I can do that;
5. My HIE Opt Out selection will remain in effect unless I change it in writing;
6. I UNDERSTAND that once this HIE Opt Out goes into effect, I can change my mind only by submitting a Cancellation of Prior HIE Opt Out form;
7. I have had an opportunity to have all my questions regarding this HIE Opt Out and others answered;
8. Any information that is disclosed before I submit this HIE Opt Out cannot be taken back and will remain with my provider who may have accessed such information before this Opt Out went into effect; and
9. All efforts will be made to process this request within ten (10) business days.

**If this form is signed by someone other than the person named above, the person signing the form hereby certifies that they are acting as:** (CHECK ONE) ___ Parent ___ Legal Guardian
___ Other (Specify Relationship) _____ for the person named above.

**Contact Information for Individual Completing This Form If Other Than Patient (Please Print Clearly)**
Printed Name_____ Phone Number_____

**Patient Information (Please Print Clearly)**
Printed Name_____ Signature_____
Date_____

**********Internal Usage**********
Date Completed: _____ Processed By (Name):_____

If you wish to reverse your decision you may opt back in at any time by calling Health Information Management Department at 1-609-303-4085.

**Mail your completed form to:**
Capital Health
One Capital Way
Pennington, NJ 08534
Attn: Health Information Management

**Or Fax your completed form to:**
1-609-303-4093