Health Information Exchange (HIE) Opt-Out Request Form

Patient Information:

- **Full Name: _____**
- **Date of Birth: _____**
- **Address: _____**
- **City, State, ZIP Code: _____**
- **Phone Number: _____**
- **Email (optional): _____**

Opt-Out Request:
I understand that my health information is securely shared through the Health Information Exchange (HIE) to improve coordination of care among healthcare providers. I request to opt-out of participation in the HIE, which means my health information will not be shared electronically through the exchange.

- **I acknowledge that opting out may affect my healthcare providers' ability to access important health information.**
- **I understand that this request only applies to electronic sharing through the HIE and does not prevent my healthcare providers from sharing information through other means, such as fax or mail.**
- **I understand that I may opt back in at any time by submitting a written request.**

☐ I request to opt-out of HIE participation.
☐ I request to opt back in to HIE participation.

Signature: _____
Date: _____

For Office Use Only:

- **Received by: _____**
- **Date Received: _____**
- **Processed by: _____**
- **Date Processed: _____**