

CAMDEN HIE 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 **OPT OUT of the Camden HIE**. I understand that by making this selection, **NONE** of my healthcare providers will be able to access my health information maintained on the Camden HIE, even in cases of a medical emergency;
2. I UNDERSTAND that my providers who originally recorded information about me **will continue to have access** to my information, but only in the medical record that they created for me;
3. I understand that this Camden HIE Opt-Out does NOT mean that I am opting-out of any *other* HIE. I understand that if I wish to opt-out of another HIE, I must communicate with my provider participating in such other HIE about how I can do that;
4. My Camden HIE Opt-Out selection will remain in effect unless I change it in writing;
5. I UNDERSTAND that once this Opt-Out goes into effect, I can change my decision **only by** submitting a Revocation of Prior Camden HIE Opt-Out form;
6. I have had an opportunity to ask and receive answers to all my questions about this Camden HIE Opt-Out;
7. Any information that is disclosed before I submit this Camden HIE Opt-Out cannot be taken back and will remain with my provider if he/she accessed such information before this Opt-Out went into effect; and
8. This request can take up to **2 business days** to take effect.

Signature: _____ Date: _____

If Legal Representative, state Authority: _____

Completed and signed Camden HIE Opt-Out form can be returned to Registration/Reception Desk; faxed to (856) 355-2196; or mailed to:

***Virtua Health Information Management
Camden HIE
5 Eves Drive, Suite 120A
Marlton, NJ 08053***