HEALTH INFORMATION EXCHANGE (HIE) OPT-OUT

Patient Name (First, Middle, Last) _____

Home Address _____

Date of Birth _____ Telephone Number _____

Email Address: _____

By signing below, I acknowledge and agree as follows:

1. I wish to opt-out of the HIEs in which Virtua participates. A list of the HIEs that Virtua currently participates in is available at https://www.virtua.org/HIE. I understand that by making this decision my health information will not be shared by Virtua through these HIEs to any HIE participants outside of Virtua involved in my care, even in cases of a medical emergency.

2. I understand that opting out of the HIEs does not prohibit Virtua from sharing my information with others involved in my care, as permitted by law, by methods other than the HIE, such as by phone, fax, mail, or other electronic communications.

3. I understand that this HIE Opt-Out Form only prohibits Virtua from sharing my health information through the HIEs that Virtua participates in. I understand that my non-Virtua health care providers may also participate in HIEs. If I wish to opt-out of HIEs my non-Virtua providers participate in, I am responsible for contacting each of my non-Virtua health care providers for information on how to opt-out.

4. I understand that providers throughout Virtua use a common electronic medical record system. This HIE Opt-Out form will not prohibit or prevent my health information from being accessed and shared by my various Virtua providers through the electronic medical record system.

5. I understand that this opt-out will remain in effect unless I choose to opt back in. I may opt back in at any time by completing Virtua's *Cancellation of Health Information Exchange (HIE) Opt-Out Form* and submitting as indicated on the form.

6. This opt-out may take up to five (5) business days after receipt by Virtua to take effect.

7. This opt-out does not apply to any of your health information shared by Virtua through the HIEs before this opt-out takes effect.

_____ _____

Signature of Patient or Patient's Legal Representative (as applicable) | Date

_____ _____

Name of Patient's Legal Representative (Print) | Relationship to Patient or Statement of Authority to act on Patient's Behalf (i.e. spouse, parent, legal guardian, person acting *in loco parentis*, etc.)

Please complete and submit this form in person to Virtua registration staff, or by mail to Virtua Health Information Management Department, 406 Lippincott Drive, Suite J, Marlton, NJ 08053.

	Virtua Health		
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For Virtua Use Only:

Date Received: _____ Date Completed: _____ Initials: _____