CANCELLATION OF 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 cancel my previous decision to opt-out of the HIEs in which Virtua participates. I understand that by making this decision I am authorizing my health information to be shared by Virtua through these HIEs. I understand that the information shared may include information of a more sensitive nature, including but not limited to: genetic diseases or tests, substance use disorder, mental health conditions, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), sexually transmitted diseases (STDs), and birth control and abortion (family planning).

2. I understand that if I change my mind, I may at any time later opt back out of the HIEs in which Virtua participates by completing and submitting a new *Health Information Exchange (HIE) Opt-Out Form* as indicated on the form.

3. This cancellation of opt-out status request can take up to five (5) business days after receipt by Virtua to take 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: _____