HEALTH INFORMATION EXCHANGE (HIE) OPT-OUT

Patient 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 Princeton HealthConnect HIE.** I understand that by making this selection, **NONE** of my health care providers will be able to access my health information maintained anywhere on the Princeton HIE, even in cases of a medical emergency, nor will I be able to access my own medical record information in the Princeton HIE Patient Portal.

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 Princeton HealthCare System (PHCS) to make my health information available to other connected Health Information Exchanges with whom PHCS participates, 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 Health Information Exchange. I UNDERSTAND that if I wish to opt-out of another HIE, I am responsible for approaching my provider participating in such other Health Information Exchange(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 **Opt-Out** goes into effect, I can change my mind **only by** submitting a Revocation of Prior Opt-Out form;

7. I have had an opportunity to have all my questions about this "Health Information Exchange Opt-Out" and any others answered;

8. Any information that is disclosed before I submit this Health Information Exchange 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. This request can take up to **2 business days upon receipt** to take effect.

10. I UNDERSTAND that it is **my responsibility** to notify my treating physician(s) that I have opted out of the HIE.

Patient or Representative Signature: ______________________________ Date: ____________

Legal Representative Name: ________________________ Relationship to Patient: ____________

PHCS Internal Use Only:

MR#__________ Date Received by PHCS: ____________ PHCS Signature: ____________________

Completed and signed Health Information Exchange Opt-Out form can be returned to the PHCS Health Information Management Department; faxed to 609-853-7051 or mailed to:

Princeton HealthConnect HIE
C/o Health Information Management Department
Princeton HealthCare System
One Plainsboro Road
Plainsboro, NJ 08536

Effective January 2013