Health Information Exchange (HIE) Opt-Out Form

To opt out of the HIE, complete this form and return it to your provider.

Please print clearly.

Name: _____
Last First Middle

Are you known by any other names? If yes, please list.

_____

Date of birth: _____

Social Security Number_____

Address: _____

Phone: _____

Opt Out: I do not want my health information to be included in the HIE. I have read and fully understand the information provided to me regarding the Provider HIE and opting out.

_____
Signature of Patient or Authorized Representative

_____
Name of Authorized Representative

_____
Address of Authorized Representative

_____
Date

*Please allow up to five (5) business days for your information to be included back in the system.