Opt-Out Form

This form is to be used by patients who **do not** wish to participate in the Health Information Exchange (HIE)

The Midwest Health Connection health information exchange (MHC HIE) allows you to permit your health information to be shared by participating medical groups, hospitals, labs, other health care providers, health plans, and other authorized recipients through secure, electronic means. The purpose of the MHC HIE is to give your health care providers, health plan, and other authorized recipients the ability to efficiently access medical information necessary for your treatment, payment for your care, and other lawful purposes.

Your participation in the HIE is voluntary and subject to your right to opt-out. Your receipt of treatment or health plan coverage will not be conditioned on whether or not you choose to exercise this right.

Unless you opt-out, any authorized provider, health plan or other entity that participates in the MHC HIE, or is a member of a health information exchange that is connected to the MHC HIE, can electronically access and share your health information through the MHC HIE, as set forth below.

- The health information that will be shared through the MHC HIE will include health information from both before and after today's date and may include information related to treatment you received from any provider who is connected, either directly or indirectly, to the MHC HIE, including out-of-state providers.
- The health information that will be shared through the MHC HIE includes information about your diagnoses, test results (like x-rays or laboratory), and medications that have been prescribed to you. Such information may also include health information that may be considered particularly sensitive to you, including: mental health information; HIV/AIDs information and test results; genetic information and test results; STD treatment and test results, and family planning information.
- The health information that is made available to the MHC HIE may be used by MHC HIE participants for treatment, payment, health care operations, and other authorized purposes.

By signing this form, I hereby ACKNOWLEDGE and AGREE as follows:

1. I am requesting that none of my health information be shared through the MHC HIE. This will include in emergency care situations.

2. I understand that even if I sign this form, my health information may still be disclosed by my provider to the MHC HIE, but the MHC HIE will not permit such health information to be viewed.

3. This Opt-Out request only applies to the sharing of health information through the MHC HIE, and my health care providers may have access to my health information using other methods, such as by fax, telephone, email, or mail.

4. I may choose to opt back into the MHC HIE at any time so that my health information may be shared through the MHC HIE. To opt back into the MHC HIE, I must submit a completed **"Revocation of Opt-Out Form"** to the address provided at the bottom of that form.

5. I understand that any information that was shared through the MHC HIE before the date this form is processed may remain with the participants who previously accessed such information.

6. It may take between **2 - 5 business days after receipt** to process this Opt-out form and to prevent the sharing of my health information through the MHC HIE.

Patient's Name: Last *	First*	Middle Initial
Previous Name or Nicknames:	Patient's Date of Birth:*	Primary Phone Number: * ( ) -
Postal Address:*	City:*	State:* Zip:*

*required information

_____ _____

Signature of Patient (or Legal Representative) **Date Signed**

If under 18 years, signature of Parent or Guardian

_____ _____ _____

Legal Representative Name * Relationship to Patient* Phone #*