Health Information Exchange Opt-Out Form

Anderson Healthcare

Patient Name (First, Middle, Last):

____

Date of Birth (mm/dd/yyyy): ______/_______/__________

Telephone Number: ______________________________

Address:____________________________________City:________________________State:___________ZIP: __________

This form is to be used by patients who do not wish to participate in the health information exchange. Participation in the exchange permits 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 exchange 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 exchange 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 exchange or is a member of the exchange, can electronically access and share your health information through the exchange as set forth below.

- The health information that will be shared through the exchange 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 exchange, including out-of-state providers.
- The health information that will be shared through the exchange 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 exchange may be used by exchange 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 exchange. I understand that by making this selection, health care providers outside of Anderson Hospital and its affiliated covered entities as defined in the *Notice of Privacy Practices* will not be able to access my health information maintained by Anderson Healthcare anywhere in the exchange, 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 **for the purpose of opting out**, but the MHC HIE will not permit health information to be viewed.

3. This opt-out request only applies to the sharing of health information through the exchange. My health care providers may have access to my health information using other methods, such as by fax, telephone, email, or mail.

4. This opt-out may not cover or affect my participation in any other health information exchange for organizations outside of Anderson Healthcare. I understand that if I wish to opt-out of another health information exchange, I am responsible for contacting the responsible organization.

5. I may choose to opt back into the exchange at any time so that my health information may be shared through the exchange. To opt back into the exchange, I must submit a completed "Revocation of Opt-Out Form" to the address provided at the bottom of that form as instructed on https://www.andersonhospital.org/opt-out.

6. I understand that any information that was shared through the exchange before the date this form is processed may remain with the

participants who previously accessed such information.

7. It may take between 2 to 5 business days after receipt to process this opt-out form and to prevent the sharing of my health information through the exchange.

X____ ____________ ____________
Signature of Patient or Patient's Legal Representative Date Time

____ ______________________________
Print Name of Legal Representative (if applicable) (Relationship to patient)

Completed and signed opt-out form can be returned via fax to 618-391-6100 or mailed/hand delivered to:
Anderson Healthcare
Health Information Management
6800 State Route 162
Maryville, IL 62062