3607

HEALTH INFORMATION EXCHANGE (HIE)
"ELECTRONIC NETWORK" OPT-OUT REQUEST FORM

Patient Information

Patient Name (First, Middle, Last): _____

Previous Names: _____ Date of Birth: (mm/dd/yyyy) _____

Mailing Address: _____

Contact Phone Number: _____

The health care organizations under the CareConnect network (CareConnect Partners*) strive to provide excellence in health care. As part of this endeavor, the CareConnect Partners participate in a centralized health care information exchange between participating providers by means of a secure Electronic Network program. This Electronic Network program allows participating health care providers such as doctors, hospitals and other caregivers to share and access important health information they need to make informed decisions about your care, especially in an emergency.

Participating in the Electronic Network program is voluntary. You may at your discretion, 'opt-out' of having your health care information available to your health care providers outside of the CareConnect network, that are participating in the Electronic Network program by submitting this completed form to the Health Information Management Department. By opting out of participating in the Electronic Network program, please note that your participating providers will not be able to access your health information through the Electronic Network while providing care to you at another location outside the CareConnect network, even during emergencies. The standard methods of information exchange between CareConnect Partners and your health care providers outside of the CareConnect network will continue to be available and ordering providers will continue to receive labs and test results for encounters in which they are listed as the ordering provider or on which they were copied.

Your decision whether or not to participate or opt-out from the Electronic Network program will not affect your ongoing medical care/relationship with your doctors and it will not involve any penalty or loss of benefits to which you are otherwise entitled.

By completing and signing this form, you are indicating that you would like to opt-out from having your health care information shared with the Electronic Network (Health Information Exchange).

1. I wish to opt-out of the Electronic Network. I understand that by making this selection, my health information will not be made available to any of my health care providers outside the CareConnect network through the Electronic Network program, even in cases of medical emergency.

PATIENT IDENTIFICATION

2. I understand that my opting-out of the Electronic Network does not affect the sharing of my health information within CareConnect Partners. Opting-out of this program only limits the ability of health care providers that are not affiliated with the CareConnect network to access my health information through this program.

3. I understand that my opting-out of the Electronic Network only applies to sharing my health information through this program. I understand that health care providers not affiliated with the CareConnect network may request and receive my medical information using other methods permitted by law as needed for treatment purposes.

4. I understand that my selection to opt-out of the Electronic Network will remain in effect until and unless I revoke my selection in writing by completing the corresponding 'Revocation of Opt-Out Consent' form.

5. I understand that my health information that has been already accessed by my health care provider outside the CareConnect network prior to my submission of this 'Opt-out' form cannot be retracted.

6. I understand that my selection to opt-out of the Electronic Network program may take up to 2 (two) business days to be processed.

By signing below you indicate that you have read, understand and agree to each of the above statements.

_____ _____

Patient Signature / Authorized Representative Date Signed

_____

Print Name

If this form is signed by someone other than the patient, the person signing the form hereby certifies that he/she is acting as the patient's (check one):

___Parent ___Legal Guardian ___ Other (please specify) _____

Additional information about the program, opting-out or opting-in is available by calling (909) 651-4191
FAX COMPLETED FORM TO (909) 651-4180

*CareConnect Network Partners list available at http://careconnectpartners.lluh.org

CareCONNECT

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PATIENT IDENTIFICATION