3610

HEALTH INFORMATION EXCHANGE (HIE)
"ELECTRONIC NETWORK" REVOCATION OF OPT-OUT CONSENT

Patient Information

Patient Name (First, Middle, Last): _____ MRN: _____

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

Mailing Address:_____

Contact Phone Number: _____

I hereby revoke my previous request submitted to the Health Information Management Department of the CareConnect network partners* to Opt-Out of the Electronic Network program.

At this time, I request that health information related to my encounters at the CareConnect network be made available in the Electronic Network thereby allowing my participating health care providers outside the CareConnect network to have access to my health information for the purposes of continuity of care.

I understand that this request to 'Opt-In' may take up to 2 (two) days to be processed.

I understand that this request to 'Opt-In' into the Electronic Network program shall remain in effect, and shall not expire, until the time that a revocation/Opt-Out form is submitted by me to the Health Information Management Department.

_____ _____

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) _____

For additional information please call (909) 651-4191
LLUH HIM- Fax completed form to (909) 651-4180
*CareConnect Network Partners list available at http://careconnectpartners.lluh.org

CareCONNECT

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OPT-OUT CONSENT

White - Chart Yellow - Patient 20-3610 (9-17)

PATIENT IDENTIFICATION