REQUEST TO OPT-OUT OF HEALTH INFORMATION EXCHANGE FORM

Please complete, sign and bring this form to our front desk staff.

Full Patient Name *(print):* _____ **DOB:**_____

Street Address:_____

City: State: Zip:

A Health Information Exchange ("HIE") is designed to allow participants (hospitals, physician practices, labs, pharmacies, and others) to share health information efficiently and securely by electronic means to better coordinate your healthcare needs. Participating in the **HIE** may allow for the more efficient exchange of health information as compared to faxing or transporting paper medical records between your providers. Your participation in the HIE is voluntary and subject to your right to opt-out. Your receipt of treatment will not be conditioned on whether or not you choose to participate in the HIE.

By completing this form, you have considered your option to participate in the HIE(s) chosen by Alpharetta ENT Specialists LLC and elected to OPT-OUT of participation. By choosing to OPT-OUT, you hereby acknowledge and agree as follows:

Your health information will no longer be accessible by other participants through the HIE as of the date your opt-out request takes effect.

Opting out of the HIE may delay access to important health information, which could limit your provider's ability to make the best possible decisions about your care, including in an emergency situation.

Your health information may not be viewable through the HIE, but will continue to be available to your treating providers through previously established methods, such as phone, fax, or mail.

Requests to opt out may take several days to honor and will not apply to any information exchanged with other HIE participants before that date.

By signing below, you understand and agree to the terms of this document. If you are signing on behalf of the patient, you are signing in a representative capacity and affirm that you have the legal authority to agree to these terms on behalf of the patient and bind the patient to these terms.

Only complete if patient unable to sign:

_____ _____

Signature of Patient or Legally Authorized Representative Relationship to Patient

_____ _____

Printed Name Reason Patient Unable to Sign

_____

Date