REVOCATION OF HEALTH INFORMATION EXCHANGE OPT OUT FORM

This form should only be used if you have previously opted out of participation in the HIE and now wish to opt back in to participation in the HIE. Please complete, sign and bring this form to our front desk staff.

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

Street Address: _____

City: State: Zip: _____

Alpharetta ENT Specialists LLC participates in a Health Information Exchange ("HIE") as a way of allowing your health information to be shared by HIE participants (hospitals, physician practices, labs, pharmacies, and others) more efficiently through a secure, electronic means to better coordinate your healthcare needs. Your participation in the HIE is voluntary and you previously exercised your right to opt-out of the HIE.

By signing this form, you ACKNOWLEDGE and AGREE as follows:

1. You previously exercised your right to opt-out of the HIE, but you have changed your mind and would like to revoke your prior decision to opt out of the HIE. You would now like your health information to be shared though the HIE.

2. You understand that by signing this form, your health information from both before and after the date you sign below will be shared through the HIE.

3. You understand that you may revoke your decision to permit your health information to be shared through the HIE again at any time be submitting a new completed HIE Opt-Out Request Form to **Alpharetta ENT Specialists LLC**.

4. Requests to opt back in to HIE participation may take several days to honor.

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 is unable to sign:

_____ _____

Signature of Patient or Legally Authorized Representative Relationship to Patient

_____ _____

Printed Name Reason Patient Unable to Sign

_____

Date