Provider Location:

PHIX
Physician's Health Information Exchange

OPT-OUT REQUEST FORM

I understand that participation in a Health Information Exchange (HIE) is voluntary and that if I do not want to participate I can choose to opt-out of having my health information viewable, which will include **not** making my information available in emergency situations. If I opt to not have my information shared, my ability to receive health care **will not** be affected.

Please check all boxes below indicating that you have read and understand each of the following statements.

☐ **I understand that by submitting this *HIE Opt-Out Request Form* and selecting this choice, my health information will *not* be viewable in the PHIX system or viewable by any healthcare providers through the PHIX system.**

☐ **I understand that by submitting this HIE OPT-OUT Request Form and selecting this choice my health information WILL NOT be viewable in an emergency.**

☐ **I understand that I am free to revoke this Opt-Out Form at any time and can do so by completing a *PHIX Revocation of Opt-Out Form* that can be obtained from PHIX's website www.phixnetwork.org or from my healthcare provider.**

☐ **I understand that this request only applies to sharing my health information through the PHIX system. I recognize that when I see a healthcare provider for treatment that provider may request and receive my medical information from other providers using other methods permitted by law, such as fax or mail.**

☐ **I understand that opting out will be in effect no later than 72 hours or 3 business days (whichever is greater) after receipt of this form by PHIX. My information may be visible to medical providers through the HIE until opting out is in effect.**

A separate form must be filled out for each family member requesting to opt out. **ALL FIELDS NEED TO BE COMPLETED** for this form to be processed. A contact phone number is required in case PHIX needs to contact you to ensure accuracy of your demographic information.

Patient Last Name	***First Name***	***Middle Initial***	***(Previous Names/Nicknames)***
Mailing Address	***City***	***State***	***Zip Code***
( ) - *Contact Phone Number*	***Social Security # (Last 4 digits)***		***Date of Birth (mm/dd/yyyy)***

_____ _____

Signature of Patient Date Signed

_____ _____

Signature of Parent/Guardian Date Signed

_____ _____

Parent/Guardian Name Parent/Guardian Contact Telephone

☐ Parent ☐ Guardian ☐ Other_____

Section to be completed by a Notary Public or Health Care Provider (or PHIX staff):

I witnessed the above named individual signing this document and the individual is personally known to me or provided me with valid picture identification on this day_____of_____, 20_____.

Notary or Provider
Signature:_____ Phone Number:_____

Print Name:_____ Date Signed:_____
(*Must be original signature in black or blue ink)*

PRACTICE ADMINISTRATOR: Please send the completed form via fax to 844-833-6810.

This Form is effective as of: 10/04/2013
Revised: 10/04/2013