St Christopher's Pediatric Associates participates in a Health Information Exchange (HIE). An HIE allows healthcare providers to appropriately access and securely share a patient's medical information electronically across healthcare organizations. The benefits of an HIE include information sharing that allows for timely and efficient patient centered care and provides a more complete view of a patient's health.

My signature below indicates that I have chosen to opt–out from sharing my protected health information through the HIE and I have read, understand and agree to the following statements:

- I understand that by choosing to opt–out of the HIE, my medical information will not be available to any of my health care providers through the HIE, even in cases of medical emergency.
- I understand that my choice to opt out of the HIE does not affect the sharing of my medical information between the St Christopher's Pediatric Associates. Opting-out of the HIE only limits the ability of my healthcare providers to access my medical information through the HIE.
- I understand that choosing to opt–out does not affect my ability to receive medical care.
- I understand that my health care provider may request and receive my medical information by requesting my medical record (chart) be sent to them through fax or through U.S. mail.
- I understand that my choice to opt-out of the HIE will remain in effect until I change my choice in writing or by completing the Electronic Medical Record Network (Health Information Exchange) OPT–IN form.
- I understand that any medical information shared with my health care provider(s) before I submitted this opt-out form cannot be taken back and will remain with my health care provider(s) who may have received my medical records before this opt-out form was put into place.
- I understand my choice to opt-out of the HIE may take up to five business days to process.

HEALTH INFORMATION EXCHANGE (HIE) OPT-OUT FORM

Patient Information

Patient Name (First, Middle, Last): _____

Previous Name(s): _____

MRN: _____ Date of Birth (mm/dd/yyyy): _____

Mailing Address: _____

City: _____ State: _____ Zip Code:_____

Contact Phone Number: _____

Gender: ☐ Chose not to disclose ☐ Female ☐ Male ☐ Other
☐ Transgender Female/Male–to–Female ☐ Transgender Male/Female–to–Male

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_____ _____ _____
Signature of Patient Date Time

_____
Print Patient Name

_____ _____ _____
Signature of Authorized Agent/Rep Date Time

_____
Relationship to Patient

HEALTH INFORMATION EXCHANGE (HIE) OPT-OUT FORM