HEALTH INFORMATION EXCHANGES OPT-OUT FORM

This form should be completed by patients who do not wish to participate in the Health Information Exchanges (HIEs) that have partnered with Beacon Health System (Beacon).

The HIEs are a safe way of sharing your health information among participating medical offices, hospitals, care coordinators, radiology centers, labs and other health care providers through secure, electronic means. The purpose of the HIEs is so that each of your participating health care providers can have the benefit of receiving the most up-to-date information available from your other participating providers while treating you. If you opt-out of participating in the HIEs, your providers and other practitioners will not be able to search for your health information through the HIEs to use while providing your care.

This opt-out form only needs to be completed once to opt-out of the HIEs; it is not necessary to complete for each provider.

For more information about opting out or revoking an existing opt-out request, please contact the Beacon Privacy Officer at (574) 647-7751 or send an email to HIEOPT-OUT@beaconhealthsystem.org.

By signing this form, I, hereby ACKNOWLEDGE and AGREE to the following:

1. I am requesting that my health information not be shared through the HIEs that are partnered with Beacon. **This will include in emergency care situations**.
2. This Opt-Out request only applies to the sharing of health information through the HIEs, and my health care providers may have access to my health information using other methods, such as by telephone, fax, email or mail.
3. If you wish to reverse your decision, you may opt back in at any time by completing the "HIEs Revocation of Opt-Out Request Form" online or contacting Beacon's Privacy Officer at (574) 647-7751 or send an email to HIEOPT-OUT@beaconhealthsystem.org.
4. I understand that any information that was shared through the HIEs before the date this form is processed may remain with the providers who accessed such information.
5. It may take between **2-5 business days** after receipt to process this Opt-Out form and to prevent the sharing of my health information through the HIEs.

PATIENT OPT-OUT INFORMATION

Patient Name (Print) _____ Today's Date _____
Last, First, MI

Date of Birth _____ ☐ Male ☐ Female ☐ Other/I Do Not Wish To Disclose

Address _____ Email _____
Street City State Zip Code

Primary Phone Number _____ Secondary Phone Number _____

Patient Signature _____ Date _____

If this form is submitted by someone other than the patient named above, the person submitting the form hereby certifies that he/she is acting as (CHECK ONE): ☐ Parent ☐ Legal Guardian ☐ Other

Name (Print) _____ Relationship _____
Last, First, MI

Primary Phone Number _____ Secondary Phone Number _____

I would like to be notified of my participation choice in the following way (CHOOSE ONE): ☐ Email ☐ Phone ☐ Letter ☐ No Notification

You may submit this completed form to the Privacy Officer by emailing a copy to HIEOPT-OUT@beaconhealthsystem.org or mailing the form to the following address: Beacon Health System, Attn: Privacy Officer, 615 North Michigan Street, South Bend, IN 46601.