HEALTH INFORMATION EXCHANGES
REVOCATION OF OPT-OUT REQUEST FORM

This form should be completed by patients who now wish to participate after previously opting out of 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.

Your participation in the HIEs is voluntary and your receipt of treatment or payment for treatment will not be conditioned on whether or not you sign this form.

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 completing this form, I am expressing my wishes to revoke my previous opt-out request and to resume participation in the HIEs. I understand that this form must be completed and returned to the Beacon Privacy Officer in order for my participation to resume.

PATIENT 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 _____

Signature _____ Date _____

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.