healtheconnect ALASKA **Health Information Exchange Patient Opt-Out Form**

You may Opt-In or Opt-Out of health information exchange at any time. Whichever you choose, your selection is confidential. In certain cases such as the reporting of infectious diseases to public health officials, your choice is overridden by law. Whatever your choice, in no circumstances is data provided to anyone other than your provider or your insurer as allowed by law. This is the same reporting that currently occurs with your paper health information by fax or mail. Electronic transfer allows your data to be transferred securely and provides you with an audit of where your data has been sent which paper transfers cannot guarantee.

For more information about the security and benefits of health information exchange see the healtheConnect Alaska website at www.healtheconnectak.org.

To Opt-Out, please select ONE of the following:

☐I WISH to partially **OPT OUT of** healtheConnect Alaska, allowing providers to access my health information only in the event of a medical emergency.

☐I WISH to completely **OPT OUT of** healtheConnect Alaska**.** I understand that by making this selection, **NONE** of my healthcare providers will be able to access my health information maintained at healtheConnect Alaska, even in a medical emergency;

I hereby acknowledge and agree as follows. I understand that:

1. My providers **will continue to have access** to my information, but only in the electronic medical record that was created for me by my provider; my provider will not be able to access another record from a different provider I have seen.
2. Any information that is disclosed before I submit this Alaska HIE Opt-Out form cannot be taken back and will remain with my provider if he/she accessed such information before this Opt-Out went into effect.
3. My Primary Provider will receive a copy of my Opt-Out choice from healtheConnect Alaska.
4. Once this Opt-Out goes into effect, I can change my decision **only by** submitting an Opt-In form to healtheConnect Alaska.
5. This request, and any future request to Opt-In, can take up to 3 business days after receipt to take effect.
6. If the information on this form changes, I must notify both healtheConnect Alaska and my primary care provider. If I provide information to a provider that does not match this form, that information may not be opted-out of the health information exchange.

If I have questions regarding Opt-In and Opt-Opt, I understand I can contact healtheConnect Alaska directly at 866-966-9030, ext 1.

Please Type or Print Clearly. *Denotes required fields. Forms cannot be processed without the required information.

*Patient Name (Last):	* (First):	(MI):	
Previous Names or Nicknames:	*Patient Date of Birth (mm/dd/yyyy):	*Primary Telephone Number: ( ) -	
Email:	*Sex (M/F):	Secondary Telephone Number: ( ) -	
*Address (Mailing):	* (City):	* (State):	* (Zip):
*Primary Provider Name:	Facility:	Medical Record Number (MRN):	

______________________________ ____________ ________________________________

***Signature of Patient** ***Date Signed** ***Signature of Facility Staff Member** (please complete Facility and MRN)

<u>Notary: (Form must be notarized if not witnessed by provider, clinic or hospital)</u>

STATE OF ________________

The foregoing signature was acknowledged before me this ______ day of _______________ as an authorized, free and voluntary act. IN WITNESS WHEREOF, I have hereunto set my hand and seal.

By: ______________________________________)

Notary Public for: __________________________)ss

My Commission Expires: __________________)

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