Health Information Exchange Patient Opt-Out Form

This form is to be used by patients who do not wish to participate in the regional Health Information Exchange (HIE)

A Health Information Exchange, or HIE, is a way of sharing your health information among participating doctors' offices, hospitals, care coordinators, labs, radiology centers, health plans and other health care providers through secure, electronic means. The purpose is so that each of your participating healthcare providers can have the benefit of the most recent information available from your other participating providers when taking care of you. When you opt out of participation in the HIE, doctors and nurses will not be able to search for your health information through the HIE to use while treating you. Your physician or other treating providers will still be able to select the HIE as a way to receive your lab results, radiology reports, and other data sent directly to them that they may have previously received by fax, mail, or other electronic communications. Additionally, in accordance with the law, Public health reporting, such as the reporting of infectious diseases to public health officials, will still occur through the HIE after you decide to opt out. Controlled Dangerous Substances (CDS) information, as part of the West Virginia Controlled Substances Monitoring Program (CSMP), will continue to be available through the HIE to providers.

This opt-out form only needs to be completed once to opt out of the HIE; it is not necessary to complete for each provider. If you wish to reverse your decision you may opt back in at any time by calling WVHIN at 1.844.468.5755.

You have several options for opting out of the WVHIN Health Information Exchange. Please select one below.

1. Visit the WVHIN website at http://www.wvhin.org (submit your request electronically online – paperless)
2. Call 1.844.468.5755
3. Email your completed form to wvhinsupport@crisphealth.org
4. Fax your completed form to 443.817.9587
5. Mail your completed form to WVHIN, 7160 Columbia Gateway Drive, Suite 230, Columbia, MD 21046

Information for Patient Opting Out (Please PRINT Clearly)

First Name* | Middle Name | Last Name*

Address Line 1*

Address Line 2

City* | State* | Zip Code*

Primary Phone Number* | Secondary Phone Number

Email | Date of Birth* | Sex (M/F)*

***Required**

I would like to be notified of my participation choice in the following way (contact information must be included on form): ☐ Email ☐ Phone Call ☐ Letter ☐ Text ☐ No Notification

____ Opt-out from sharing information created when you see doctors in their office.
____ Opt-out from sharing information created when you go to the hospital.

Reason for Opting Out (optional)_____

Signature of Patient or Authorized Representative **Date**

If this form is signed by someone other than the person named above, the person signing the form hereby certifies that he/she is acting as: (CHECK ONE) ____ Parent ____ Legal Guardian ____ Other (Specify Relationship) _____for the person named above.

*Contact Information for Individual Completing This Form If Other Than Patient (Please Print Clearly)**

Print Name **Phone Number**