Health Information Exchange (HIE) Opt-Out Request Form

Note: A separate form must be filled out for each family member requesting to opt out. **All required fields must be completed** for form to be processed. Phone number is required in case we need to ensure accuracy of information.

*Patient's Full Name: ______________________ *Date of Birth: ____________(mm/dd/yyyy)

Previous Name(s) or Nicknames: ______________________ Gender: ☐Male ☐Female

*Street Address: ____________ *City: ____________ *State: ______ *Zip Code: __________

*Phone: ______________________ e-mail: ______________________

* Required Field

The Georgia Health Information Network, GaHIN, Health Information Exchange (HIE) is a secure, electronic way for your participating healthcare providers to improve patient care collaboratively by sharing patient health information. The HIE assists your participating healthcare providers with viewing certain health information about you in a timely manner to effectively coordinate your healthcare needs.

After considering my option of participating in the GaHIN HIE, I have decided to OPT OUT and NOT allow my health information to be viewable by my participating healthcare providers via the MHM HIE. By choosing to OPT OUT of allowing my health information to be viewable via the GaHIN HIE, I hereby acknowledge and agree as follows:

1. Opting out of the HIE may delay access by my participating healthcare providers to important medical information.
2. I understand that by Opting Out, my health information will still be sent to the HIE but it will not be VIEWABLE from the HIE. Instead, my healthcare providers will continue to share information via previously established methods, such as phone, fax, or mail.
3. My health information will NOT be shared with other HIEs in which MHM may participate including GaHIN. By opting out of the HIE, I am also opting out of GaHIN.
4. Any information that is shared before I submit this HIE Opt-Out form may remain with providers who accessed information before this Opt-Out went into effect.
5. My HIE Opt-Out selection will remain in effect unless I change it in writing; and
6. This request can take up to 3-5 business days to take effect.

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): ______________________

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Printed Name of Patient

______________________________________ ____________________
Signature of Patient Date Signed
(If patient is under 18 years, then printed name and signature of Parent, Guardian or Other)

Please send this completed form to the MHM Privacy Officer at:

Memorial Hospital and Manor Privacy Officer 1500 E. Shotwell Street Bainbridge, GA 39819	**or**	Fax: 229-243-3306 Attn: Privacy Officer	**or**	e-mail: ShemikiaF@mh-m.org