PATIENT REQUEST TO OPT-OUT OF SECURE ELECTRONIC HEALTH INFORMATION EXCHANGE

Patient Name: ______________________________ DOB: ______________

Address: ______________________________ Email Address: ______________

City, State, Zip: ______________________________ Phone Number: ______________

I do not wish to participate in the release of my medical information from The Center via Care Everywhere to my non-The Center health care providers for my care management and treatment.

I understand that by honoring this request, The Center will not share my heath information to my other providers via secure Care Everywhere, except as otherwise authorized by State and Federal patient health information privacy laws.

I understand that my request to opt out of the Care Everywhere does not affect my non-The Center health care provider's ability to otherwise obtain my The Center health information through other approved release of information processes. Please know your information will still be available to providers for Continuity of Care.

I understand that by signing this request, my non-The Center healthcare providers may not receive automatic notification via Care Everywhere about my care provided by The Center for continuity of care purposes.

I understand that my signed request becomes effective upon receipt and processing and will remain in effect until and unless I request this to be changed.

I understand that my health information may have been shared prior to my signed request being or received processed and that this form addresses information going forward.

I understand that should I wish to rescind my request to opt out of Care Everywhere to non-The Center providers, I must submit my request in writing to The Center Health Information Management Department, 2200 NE Neff Road, Bend, Oregon 97701.

If you have questions about this form or the release of your health information, please contact The Center's Health Information Management Department at 541-382-3344 before signing.

Patient Signature: ______________________________ Date / Time: ______________

Patient Printed Name: ______________________________

If signed by an Authorized Representative, relationship to Patient: ______________________________

Authorized Representative Printed Name: ______________________________ Date: __________

Send Form to: The Center
Health Information Management, ATTN: HIM Manager
2200 NE Neff Rd., Suite 200
Bend, OR 97701