

**Wentworth-Douglass Hospital
Health Information Exchange Opt-Out Form**

This form is to be used by patients who **DO NOT** wish to participate
in the Wentworth-Douglass Hospital Health Information Exchange (HIE)

A Health Information Exchange, or HIE, is a way of allowing your health information to be accessed by participating doctor's offices, hospitals, labs, radiology centers, and other health care providers through secure, electronic means. The purpose of the HIE is to give each of your participating caregivers the benefit of the most recent information available from your other participating caregivers when providing healthcare to you. Your participation in the HIE is voluntary and subject to your right to Opt-Out.

Unless you Opt-Out, any authorized healthcare provider who agrees to participate in the HIE can also electronically access and use your Protected Health Information if needed to provide treatment to you.

If you opt out of participation in the HIE, your health care providers will **NOT** be able to search for your health information through the HIE to use while treating you. However, 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.

NOTE: This form allows you to Opt-Out for this location only.

I hereby ACKNOWLEDGE and AGREE as follows;

1. I wish to **OPT-OUT of the Wentworth-Douglass Hospital HIE**. I understand that by making this selection, **NONE** of my healthcare providers will be able to access my health information maintained on the Wentworth-Douglass Hospital HIE, even in cases of medical emergency. In addition, I understand that opting out will restrict my ability to view my health information in the Patient Portal.
2. I understand that my providers who originally recorded information about me will continue to have access to my information, but only in the medical record that they created for me;
3. I understand that this Opt-Out request only applies to sharing my health information through the Wentworth-Douglass Hospital HIE system. I recognize that when I see a health care provider for treatment, that provider may request and receive my medical information from other providers using other methods provided by law, such as fax, telephone, email, or mail;
4. I understand that this Wentworth-Douglass Hospital HIE Opt-Out request does **NOT** mean that I am opting-out of any other HIE. I understand that if I wish to Opt-Out of another HIE, I must communicate with each of my providers participating in such other HIE about how I can do that;
5. I understand that my Wentworth-Douglass Hospital HIE Opt-Out request will remain in effect unless I change it in writing;
6. I understand that once this Opt-Out goes into effect, I can change my decision only by submitting a Revocation of Opt-Out Request form;
7. I understand that any information that is disclosed before I submit this Wentworth-Douglass Hospital HIE Opt-Out request cannot be taken back and will remain with my provider if he/she has accessed such information before this Opt-Out went into effect; and
8. This request to Opt-Out can take up to **5 business days after receipt** to take effect.

If this form is signed by someone other than the person named below, 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 below:

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

Printed Name *

Phone Number *

Patient's Name: Last *	First*	Middle Initial
Previous Name or Nicknames:	Patient's Date of Birth:*	Primary Phone Number: * () -
Email:	Sex (M/F):*	Secondary Phone Number: () -
Postal Address:*	City:*	State:* Zip:*

*required information

Signature of Patient (or Authorized Representative)
If under 18 years, signature of Parent or Guardian

Date Signed

Completed and signed Health Information Exchange Opt-Out forms can be returned to the Medical Information Department; faxed to (603) 740-2290 or mailed to: Wentworth-Douglass Hospital, C/o Medical Information Department, 789 Central Ave, Dover, NH 03820