HIE Opt-Out Form

1. I wish to opt-out of the HIEs in which Beth Israel Deaconess HealthCare (BIDHC) participates. I understand that by making this decision my health information will not be shared by BIDHC through these HIEs to any HIE participants outside of BIDHC involved in my care, even in cases of a medical emergency.

2. I understand that this HIE Opt-Out Form only prohibits BIDHC from sharing my health information through the HIEs that BIDHC participates in. I understand that my non-BIDHC HealthCare providers may also participate in HIEs. If I wish to opt-out of HIEs my non-BIDHC providers participate in, I am responsible for contacting each of my non-BIDHC health care providers for information on how to opt-out.

3. I understand that this opt-out will remain in effect unless I choose to opt back in. I may opt back in at any time by completing BIDHC's **Cancellation of Health Information Exchange (HIE) Opt-Out Form** and submitting as indicated on the form.

4. This opt-out does not apply to any of your health information shared by BIDHC through the HIEs before this opt-out takes effect.

I understand that it may take up to ten business days, from date of receipt, for this request to be implemented.

X____
Patient's Signature

____
Print Name

Date: ____/____/____ Time: ___ ___: ___ ___ ○ a.m. ○ p.m.

OR
X____
Signature of Person authorized to sign for patient

____________________________________ **and** __________________
Print Name Relationship to patient

Date: ____/____/____ Time: ___ ___ : ___ ___ ○ a.m. ○ p.m.

Please submit completed form at your practice front desk or mail to BIDHC Health Information, 464 Hillside Avenue, Suite 304, Needham MA 02494.