



Cancellation of Health Information Exchange (HIE) Opt-Out Form

1. I wish to cancel my previous decision to opt-out of the HIEs in which Beth Israel Deaconess HealthCare (BIDHC) participates. I understand that by making this decision I am authorizing my health information to be shared by BIDHC through these HIEs. I understand that the information shared may include information of a more sensitive nature, including but not limited to: genetic diseases or tests, substance use disorder, mental health conditions, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), sexually transmitted diseases (STDs), and birth control and abortion (family planning).

2. I understand that if I change my mind, I may at any time later opt back out of the HIEs in which BIDHC participates by completing and submitting a new **Health Information Exchange (HIE) Opt-Out Form** as indicated on the form.

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

<input checked="" type="checkbox"/> _____		
Patient's Signature		

Print Name		
Date: ___/___/___ Time: ___:___ o a.m. o p.m.		
OR		
<input checked="" type="checkbox"/> _____		
Signature of Person authorized to sign for patient		
_____	and	_____
Print Name		Relationship to patient
Date: ___/___/___ Time: ___:___ o a.m. o 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.