EMORY
HEALTHCARE

Emory Health Information Exchange Opt-Out Form

*Name: _____ *Date of Birth: _____

*Street Address: _____*City: _____

*State: _____ *Zip: _____*Phone: _____

e-mail: _____ *Required Field

The Emory 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 Emory HIE, I have decided to OPT OUT and NOT allow my health information to be viewable by my participating healthcare providers via the Emory HIE. By choosing to **OPT OUT** of allowing my health information to be viewable via the Emory 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 Emory 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 Emory Healthcare may participate including the Georgia Health Information Network (GaHIN). By opting out of the Emory HIE, I am also opting out of the 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) _____ for the person named above.

Printed Name: _____ Date: _____

Signature: _____

Please forward the completed and signed HIE Opt-Out Forms to the Emory HIE by one of the following methods:
Fax to: 404-712-2980 or Email to: ehc.hie.administrator@emoryhealthcare.org