Health Information Exchange Opt-Out Request

MR#:	*Patient Name: (please print)	*DOB: mm/dd/yyyy	*Facility:

A separate form must be completed by each family member wishing to Opt Out. Please complete all of the required fields for accurate processing. *Please print legibly* with a black ballpoint pen.

Health Information Exchange (HIE) is the sharing of health information electronically across organizations. SacValley MedShare (SVMS) operates an HIE Network among SVMS regions and participates in several HIE networks with other health care providers outside of SVMS and may share your health information electronically with other organizations such as public health departments, health plans, health care providers, and other participants. Exchanging information electronically is a faster way to share your health information with healthcare providers treating you. For example, if you go to a hospital emergency room that participates in the same HIE network as SVMS, the emergency room physicians would be able to access your SVMS health information to help make treatment decisions for you. HIE participants like SVMS are required to meet rules that protect the privacy and security of your health and personal information.

If you do not want your health information shared through an HIE network, please complete this form and return it to the address below. By completing this form, you request that SVMS not share your health information electronically through the Health Information Exchange with other regions or outside organizations. At this time, if you decide to Opt Out of exchanging your information, none of your information will be shared through an SVMS HIE network., even in an emergency. In other words, opting out is an "all or nothing" concept. A request to opt out of an HIE will be effective approximately five (5) business days after receipt by SVMS. It will not apply to any information sent through the HIE or exchanged with other participants in an HIE network before that date. You are free to opt back in at any time by completing an Opt-Out Revocation Form that can be obtained from Membership Services or downloaded from http://sacvalleyms.org.

Fields marked with (*) are required fields for opt-out processing completion.

530-487-4997 info@sacvalleyms.org www.sacvalleyms.org
2485 Notre Dame Blvd. Suite 370-20 Chico, CA 95928

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Please print legibly. Social Security Number:	

*First Name	*Last Name	*DOB: mm/dd/yyyy

Mailing Address

Street Address	City	State	Zip

Telephone Number	Medical Record Number

Sex: ☐ **Male** ☐ **Female** ☐ **Other (check one box only)**

Signature (Required): **Date:**

Print Authorized Representative's Name **Relationship to Patient**

_____ _____

Please Mail the Completed Form To:

SacValley MedShare, 2485 Notre Dame Blvd. Suite 370-20 Chico, CA 95928

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