UPMC Susquehanna

OPT-OUT FORM

FOR ELECTRONIC HEALTH INFORMATION EXCHANGE

INSTRUCTIONS:

STEP 1—Please review the patient guide brochure prior to completing this form.

STEP 2—Complete **Sections 1 and 2** below to opt-out of electronic health information exchange. Please initial that you have read and understand each of the following statements in Section 1.

Section 1—To **opt-out** of the electronic health information exchange, please initial each below:

_____ By submitting this opt-out form, information about me **will not** be accessible to healthcare professionals and other authorized users (including emergency services) by use of the electronic health information exchange.

_____ This request does not prohibit my healthcare provider from otherwise disclosing my medical information pursuant to other authorizations and applicable laws, or by other methods, including fax.

_____ I may choose to participate in electronic health information exchange again at any time by submitting an opt-back-in form which can be obtained at any registration location at UPMC Susquehanna.

Section 2—Please complete the section below:

Patient First Name: _____ Patient Last Name: _____

Patient Date of Birth: _____/_____/_____ Patient MRN: _____

By signing this form, I verify that I am the person named above, or that I am legally authorized to complete and sign this form for the person named above. The information provided on this form, and the preferences expressed herein, are true and correct to the best of my knowledge, information, and belief.

Patient Signature: _____ Date:_____

Parent/Guardian or Representative: _____Relationship to Patient:_____

Signature of patient, parent, legal guardian, or legal representative where required. If legal guardian or representative, please state your relationship to the patient.

PLEASE RETURN THIS COMPLETED FORM TO:

David Samar, HIPAA Privacy Officer, 700 High Street, Williamsport PA 17701

UPMC Susquehanna

OPT-BACK-IN FORM

FOR ELECTRONIC HEALTH INFORMATION EXCHANGE

INSTRUCTIONS:

STEP 1—Please review the patient guide brochure prior to completing this form.

STEP 2—Complete **Sections 1 and 2** below to opt back into electronic health information exchange. Please initial that you have read and understand the following statement in Section 1.

Section 1—To **opt back into** electronic health information exchange, please initial each below:

_____ By completing this section, information about me (including information created prior to today's date) **will** be accessible to healthcare professionals and other authorized users (including emergency services) by use of the electronic health information exchange.

Section 2—Please complete the section below:

Patient First Name: _____ Patient Last Name: _____

Patient Date of Birth: _____/_____/_____ Patient MRN: _____

By signing this form, I verify that I am the person named above, or that I am legally authorized to complete and sign this form for the person named above. The information provided on this form, and the preferences expressed herein, are true and correct to the best of my knowledge, information, and belief.

Patient Signature: _____ Date:_____

Signature of patient, parent, legal guardian, or legal representative where required. If legal guardian or representative, please state your relationship to the patient.

PLEASE RETURN THIS COMPLETED FORM TO:

David Samar, HIPAA Privacy Officer, 700 High Street Williamsport PA 17701