SHORE MEDICAL CENTER

Somers Point, NJ 08244

PATIENT ID/LABEL HERE:

HEALTH INFORMATION EXCHANGE (HIE) REVOCATION OF PRIOR OPT-OUT

Patient Name *(First, Middle, Last):* _____

Home Address: _____

Date of Birth: _____Phone: _____

E-Mail: _____

I hereby acknowledge and agree as follows:

1. I wish to cancel my prior decision to Opt-Out of the HIEs which SMC participates. I now specifically authorize my information maintained in the HIEs to be electronically available to my providers;
2. I understand that by making this selection, ALL of my authorized providers who participate in the HIEs or are connected to the HIEs will now have access to my health information maintained in the HIEs;
3. I understand that by making this selection, my health information may be accessible by other HIEs with whom the HIEs participate;
4. I understand that this cancellation can only be changed if I specifically submit a new HIE Opt-Out form;
5. I have had an opportunity to have all my questions regarding this cancellation of prior Opt-Out and others answered; and
6. This request can take 2 business days to take effect.

_____ _____

Signature: Date:

If Legal Rep, state Authority: _____

Completed and signed Health Information Exchange Health Information Exchange Revocation of Prior Opt form can be returned to the SMC Health Information Management Department; faxed to 609-653-3805 or mailed to:

SMC HIE c/o Health Information Management Services (HIMS)
100 Medical Center Way
Somers Point, NJ 08244

For SMC Use Only:

Date Received: _____ Date Completed: _____ Initials: _____