SHORE MEDICAL CENTER

Somers Point, NJ 08244

HEALTH INFORMATION EXCHANGE (HIE) 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 OPT OUT of the HIEs in which SMC participates. I understand that my providers who originally generated information about me will continue to have access to my information, but only in the medical record that they created for me, or by obtaining it via previously established methods;

2. I understand that by making this selection, my health information will not be shared by SMC through these HIEs to any HIE participants outside of SMC involved in my care, even in the case of a medical emergency;

3. I understand that this HIE Opt-Out does NOT cover or effect my opting out of any other HIE. I understand that if I wish to opt-out of another HIE, I am responsible for approaching my provider who participates in another HIE about how I can do that;

4. I understand that providers throughout SMC use a common electronic medical record system. This HIE Opt Out form will not prohibit or prevent my health information from being accessed and shared by my various SMC providers through the electronic medical record system.

5. My HIE Opt-Out selection will remain in effect unless I change it in writing by submitting a Cancellation of Prior HIE Opt-Out form;

6. I understand a cancellation of a prior opt-out will not bring back the opted-out information;

7. I have had an opportunity to have all of my questions about this HIE Opt-Out, and any others answered;

8. Any information that is disclosed before I submit this HIE Opt-Out cannot be taken back and will remain with my provider who may have accessed such information before this Opt-Out went into effect; and

9. This request can take up to two business days to take effect.

_____ _____

Signature: Date:

If Legal Rep, state Authority: _____

Completed and signed Health Information Exchange Opt-Out 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: _____