ARCHBOLD MEDICAL CENTER
P. O. Box 1018 • Thomasville, GA 31799-1018

HIPAAUTH

Health Information Exchange (HIE) Opt-Out

Name: _____ Date of Birth: _____ / _____ / _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Medical Record Number (if known): _____

I hereby acknowledge and agree as follows:

1. I WISH TO **OPT-OUT of the HIE.** I understand that by making this selection, **NONE** of my health care providers will be able to access my health information maintained anywhere on the HIE, even in cases of a medical emergency;
2. 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;
3. I UNDERSTAND that this **HIE Opt-Out** will NOT allow Archbold Medical Center to make my health information available to other connected Health Information Exchanges with whom Archbold Medical Center participates, even in cases of a medical emergency;
4. I UNDERSTAND that this **HIE Opt-Out** does NOT cover or effectuate my opting-out of any other Health Information Exchange. I UNDERSTAND that if I wish to opt-out of another HIE, I am responsible for approaching my provider participating in such other Health Information Exchange(s) about how I can do that;
5. **My HIE Opt-Out** selection will remain in effect unless I change it in writing;
6. I UNDERSTAND that once this **Opt-Out** goes into effect, I can change my mind **only by** submitting a Revocation of Prior Opt-Out form;
7. I have had an opportunity to have all my questions about this "Health Information Exchange Opt-Out" and any others answered;
8. Any information that is disclosed before I submit this Health Information Exchange 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 **5 business days upon receipt** to take effect; however, I understand my information will be accessible until that time.

Signature: _____ Date: _____

Legal Representative Name: _____ Relationship to Patient: _____

Completed and signed Health Information Exchange Opt-Out form can be returned to Archbold Medical Center's Health Information Management Department; faxed to 229-584-5938 or 229-227-5181 or mailed to:

ArchHIE – Archbold Medical Center
c/o Health Information Management Department
900 Cairo Road
Thomasville, GA 31792

For Internal Processing:
Date Received by ArchHIE/Archbold Medical Center: _____

Date Processed: _____ HIM Representative's Signature: _____