Health Information Exchange Patient Opt-Out Form

This form is to be used by patients who do not wish to participate in Jersey Health Connect Regional Health Information Organization

A Health Information Exchange, or HIE, is a way of sharing your health information among participating doctors' offices, hospitals, labs, radiology centers, and other health care providers through secure, electronic means. The purpose is for participating caregivers to have the benefit of the most recent information available from your other participating caregivers when taking care of you. When you opt out of participation in the HIE, doctors and nurses will not be able to obtain your health information through the HIE to use while treating you. Your physician or other treating providers will still be able to select the HIE as a way to receive your lab results, radiology reports, and other data sent directly to them that they may have previously received by fax, mail, or other electronic communications. Public health reporting, where applicable, in accordance with law such as the reporting of infectious diseases to public health officials, will also occur through the HIE after you decide to opt out.

This opt-out form only needs to be completed once to opt out of the HIE; it is not necessary to complete for each provider. If you do not live in New Jersey but still receive care in New Jersey, you should complete this form to opt out. If you wish to reverse your decision you may opt back in at any time by calling Jersey Health Connect at 609-945-3957. Please note: Opt out requests will be processed within three (3) business days.

Mail your completed form to: Privacy and Security Officer
Jersey Health Connect
782 Alexander Road
Princeton, NJ 08543

or Fax your completed form to: 609.945.5315

Information for Patient Opting Out (Please PRINT Clearly)

Hospital Name ____

Patient First Name*	
Patient Middle Name	
Patient Last Name*	
Address Line 1*	
Address Line 2	
City*	
State*	
Zip Code*	
Primary Phone Number*	
Secondary Phone Number	
Email	
Date of Birth*	
Sex (M/F)*	

Reason for Opting Out (optional): ____
If this form is signed by someone other than the person named above, the person signing the form hereby certifies that he/she is acting as: (CHECK ONE) ____ Parent ____ Legal Guardian ____ Other (Specify Relationship) _______________________ for the person named above.

*Contact Information for Individual Completing This Form If Other Than Patient (Please Print Clearly)**

Printed Name____ Phone Number__________________________________
*Patient Information (Please Print Clearly)**

Printed Name ____Signature____

Date____