COMMUNITY HEALTH TECHNOLOGY NETWORK

OPT OUT FORM

As a patient, you have the right to request that Community Health Technology Network (CHTN) opt you out of certain uses and disclosures of your patient information. Please check the use and disclosure(s) that you are requesting to opt out of below.

When completed, please return this form to:

Community Health Technology Network
ATTN: HIE Department
100 E. Michigan Ave, Ste. 301
Jackson, MI 49201
or
Fax: (517) 205-6991

This form **must** be signed and dated: incomplete forms will be returned to you unprocessed. You will be notified in writing when your request has been processed. If you choose to "Opt Back In", please contact the HIE Department using the contact information above.

If the requestor is the personal representative, please attach certifying documentation of your status as the personal representative, such as a Durable Medical Power of Attorney or Guardianship papers. A scanned copy of the personal representative documentation will be kept on file per policy.

REQUESTOR INFORMATION

Patient: _____ _____
(Name of Patient) (Date of Birth)

Requested by (if other than the patient): _____ _____
(Personal Representative of Patient) (Relationship to Patient)

Requestor Contact Information: _____ _____
(Street Address) (City/State/Zip) (Telephone)

Patient/Requestor Signature: _____ _____ _____
(Signature) (Date) (Time)

Health Information Exchange (HIE) allows Community Health Technology Network (CHTN) to share your patient information electronically for continuity of your care. This provides other treating providers real-time access to your patient information – without having to wait for your information to be transferred from one facility to another. You have the right to "opt out" of the Health Information Exchange by checking the box below: ***Please be aware that this Opt Out restriction may not apply in emergency situations.***

☐ I hereby request that my patient information **not** be shared via the Health Information Exchange. I understand that this request only applies to the sharing of my medical records with other treating providers who can receive data electronically.

I understand that any information that was shared through the CHTN HIE before the date of this form is processed may remain with the providers who accessed such information.

FOR CHTN USE ONLY

Received By: _____ Date Received: _____ Date forwarded to Interface Team: _____

Date scanned/filed: _____ Date of opt out confirmation letter sent to patient: _____

Comments: _____