Patient Opt Out of Certain Uses and Disclosures Form

Patient Label

DATE:

MRN:

NAME

Date of Birth:

As a patient, you have the right to request that Henry Ford Health System (HFHS) opt you out of certain uses & disclosures of your patient information. Please check the use and disclosure (s) that you are requesting to opt out of below and complete the coordinating section.

☐ **Care Everywhere** (Section A) ☐ **Health Information Exchange (HIE)** (Section B)

☐ **Operational Use** (Section C)

When completed, please return this form to: Henry Ford Health System, ATTN: Information Privacy & Security Office, One Ford Place, Suite 2A, Detroit, MI 48202, or Fax: (313) 874-9449, or email to IPSO@hfhs.org. If you choose to email this form, please be aware that email is not encrypted and your information could be viewed while in electronic transit.

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 Information Privacy & Security Office using the contact information above.

REQUESTER INFORMATION

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. The documentation will be scanned into the patient's medical record.

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

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

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

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

SECTION A – OPT OUT OF CARE EVERYWHERE

Care Everywhere allows Henry Ford Health System (HFHS) to share your patient information electronically for continuity of your care with other providers who use Care Everywhere. 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 Care Everywhere by checking the box below: ***Please be aware that this Opt Out restriction may not apply in emergency situations.***

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

I understand that any information that was shared from HFHS through Care Everywhere before the date this form is processed may remain with the providers who accessed such information.

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SECTION B – OPT OUT OF HEALTH INORMATION EXCHANGE (HIE)

HIE allows Henry Ford Health System (HFHS) 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:

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

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

SECTION C – OPT OUT OF OPERATIONAL USE

HFHS may use certain patient information to perform operational activities without your authorization. You have the right to "opt-out" of these operational activities by checking the appropriate box(es) below:

☐ I hereby request that my patient information **not** be used for *marketing* campaigns and remove my name from any and all future communications.

☐ I hereby request that my patient information **not** be used for *fundraising* campaigns and remove my name from any and all future communications.

☐ I hereby request that my patient information **not** be used for *Satisfaction Surveys* and remove my name from any and all future communications.

☐ I hereby request that my patient information **not** be used to contact me for participation in *Research Studies.*

FOR HFHS USE ONLY

For IPSO Use Only

Received By: _____ Date Received: _____ Date forwarded to Medical Records: _____
(Initials)

For HIM Use Only
Date scanned/Inserted into medical record or file: _____

Comments: _____