REQUEST TO OPT OUT OF PARTICIPATION IN ELECTRONIC HEALTH INFORMATION EXCHANGES

Organization: ______________________

Patient Name: ______________________
Address: ______________________
____
Birthdate: ______________________
Medical Record No.: ______________________

INSTRUCTIONS:

Geisinger[1] and other entities participating in our Shared Electronic Health Record (EHR)[2], participate in health information exchanges (HIEs) that allow physicians and other authorized healthcare professionals to access your protected health information (PHI) for care coordination and continuity of care. We only use and share PHI via HIEs as explained in our Notice of Privacy Practices, which is available at www.geisinger.org/HIPAA, and in accordance with HIPAA and other applicable privacy laws. When participation is not mandated by law or otherwise required, you may opt out of participating in these HIEs, by completing this form.

Please carefully review this form, sign and date below.

I understand that by submitting this form, PHI about me in the medical record will not be accessible through HIEs to providers and other healthcare professionals (including emergency services), unless such access is mandated or otherwise required by law.

This request does not prohibit disclosure of PHI about me pursuant to other authorizations and applicable laws, or by other methods, including fax or mail.

This request does not prohibit the disclosure of PHI for treatment, payment and healthcare operations or other purposes permitted under law, except that such information will not be disclosed via an HIE, unless such sharing is mandated or otherwise required by law.

I may choose to allow my PHI to be accessible through HIEs again at any time by updating my preferences with registration staff, or by submitting a written request to my provider.

Patient Signature: ______________________ Date/Time: ______________

If patient is a minor under age 18 (unemancipated) or if patient is unable to give consent, the parent or legal representative should instead complete the following:

Parent/Legal Representative Signature: ______________________

Relationship to Patient/Legal Authority to Sign: ______________________

Date/Time: ______________________

[1]The term “Geisinger” shall refer to the entire health care system comprised of Geisinger Health (“GH”) as parent and all subsidiary corporate entities
[2]For a current list of entities participating in the Geisinger Shared EHR, please visit www.geisinger.org/hipaa