WATSON CLINIC LLP

Quality Healthcare for Every Generation

WATSON CLINIC #

HEALTH INFORMATION EXCHANGE (HIE) OPT-OUT FORM

HIE is the electronic sharing of health information across other organizations, including those using the EPIC Health System. Exchanging information electronically is a faster way to share your health information with health care providers treating you. For example, if you go to a hospital emergency room that participates in these networks, the emergency room physicians would be able to access your Watson Clinic LLP health information to help make treatment decisions for you. These organizations like Watson Clinic LLP are required to meet the rules that protect the privacy and security of your health and personal information.

If you do not want your health information shared through these HIE exchanges, please complete this form. A separate form must be completed by each family member wishing to **Opt-Out**.

By signing this form, I hereby acknowledge and agree as follows:

1. I request that my health information no longer be shared through the Health Information Exchange to all health care providers involved in my care who participates in or is connected to the HIE. This includes emergency care situations.
2. I understand that this revocation only applies to the sharing of health information through the HIE. My health care providers may still have access to my health information using other methods, such as fax, telephone, email or mail.
3. I understand that any information that was shared through the HIE before the date this form is processed will remain available to providers who request access.
4. A request to opt-out of the HIE will be effective in approximately 5-7 business days after receipt by the Clinic to process my request to prevent the sharing of my health information through HIE.
5. I may choose to opt back into the HIE at any time so that my health information may be shared through HIE exchanges, if applicable. To opt back into the HIE, I must revoke this form by completing the Consent for Sharing of Health Information 17 MESS 296 by requesting the form at a reception desk at any Clinic location.

Patient's Last Name:	Patient's First Name:		Middle Initial:
Previous Name or Nicknames:	Patient's Date of Birth:	Primary Phone Number:	Clinic Number:
Postal Address:	City:	State:	Zip:

Signature of Patient or Legal Representative: _____ Time:_____ Date:_____

If under 18 years, Signature of Parent or Guardian:

Legal Representative: _____ Relationship to Patient: _____

Time:_____ Date:_____

Return completed form to:

Watson Clinic Privacy Office
1600 Lakeland Hills Blvd.
Lakeland, FL 33805
Fax: 863-680-7058

STAFF USE ONLY

Received by: _____
STAFF NAME AND DEPARTMENT *EXT.*

Date:_____