

Health Information Exchange Patient Opt-Out Form

This form is to be used by patients who <u>do not</u> wish to participate in the regional Health Information Exchange (HIE).

A Health Information Exchange, or HIE, is a way of sharing your health information among participating doctors' offices, hospitals, care coordinators, labs, radiology centers, and other health care providers through secure, electronic means. The purpose is so that each of your participating healthcare providers can have the benefit of the most recent information available from your other participating providers when taking care of you. When you opt out of participation in the HIE, doctors and nurses will not be able to search for 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. Additionally, in accordance with the law, Public health reporting, such as the reporting of infectious diseases to public health officials, will still occur through the HIE after you decide to opt out. Controlled Dangerous Substances (CDS) information, as part of the Maryland Prescription Drug Monitoring Program, will continue to be available through the HIE to licensed providers.

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 the District of Columbia or Maryland, but still receive care in the region, 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 CRISP at 1.877.952.7477.

You have several options for opting out of the CRISP Health Information Exchange. Please select one below.

- 1. Visit the CRISP Web site at http://www.crisphealth.org
- 2. Call 1.877.952.7477
- 3. Fax your completed form to 443.817.9587
- 4. Mail your completed form to CRISP, 7160 Columbia Gateway Drive, Suite 230, Columbia, MD 21046

Information for Patient Opting Out (Please PRINT Clearly)

First N	Name*						
Middle	e Name						
Last N	Name*						
Addre	ess Line 1*						
Addre	ess Line 2						
City*			State*			Zip Code*	
Prima	ry Phone Number	*					
Secor	ndary Phone Num	oer					
Email							
Date	of Birth*						
Sex (I	M/F)*						
	ld like to be notifie led on form):	ed of my par Email	ticipation choice ir □ Phone Call			ontact inform	
Opt-c	out from sharing in	formation cr	eated when you se	ee doctors in	their offic	ce.	* Required
Opt-o	out from sharing in	formation cr	eated when you go	o to the hosp	ital.		
Reason for	Opting Out (option	onal):					
acting as: (s signed by someon CHECK ONE) on named above.		•		_	_	reby certifies that he/she is
Contact Inf	formation for Indiv	idual Compi	leting This Form I	Other Than	Patient (Please Print	Clearly)*
Printed Name				Phone I	Number		
Patient Info	ormation (Please I	Print Clearly	·)*				
Printed Na	me						
Signature				Date _			Version: January 2016