



# Health Information Exchange Patient Opt-Out Form

If you choose to completely opt out of participation in the HIE, doctors and nurses will not be able to search the HIE for health information to use while treating you. If you choose to partially opt out of the HIE, your health information will only be accessible through the HIE in the event of an emergency. In either case, legally required public health reporting, such as the reporting of infectious diseases to public health officials, will occur through the HIE after you decide to opt out. This is the same reporting that currently occurs with your health information, with simply a different method of communication.

For more information about the HIE and the benefits it provides, please see the AeHN website at [www.ak-ehealth.org](http://www.ak-ehealth.org).

Please select ONE of the following:

- I WISH to completely **OPT OUT of the Alaska HIE**. I understand that by making this selection, **NONE** of my healthcare providers will be able to access my health information maintained on the Alaska HIE, even in cases of a medical emergency;
- I WISH to partially **OPT OUT of the Alaska HIE**, allowing providers to access my health information only in the event of a medical emergency.

I hereby acknowledge and agree as follows:

1. I UNDERSTAND that my providers who originally recorded information about me **will continue to have access** to my information, but only in the medical record that *they* created for me, not through the HIE;
2. My Alaska HIE Opt-Out selection will remain in effect unless I change it in writing;
3. I UNDERSTAND that once this Opt-Out goes into effect, I can change my decision **only by** submitting an Opt In form to AeHN;
4. I have had an opportunity to ask and receive answers to all my questions about this Alaska HIE Opt-Out;
5. Any information that is disclosed before I submit this Alaska HIE Opt-Out cannot be taken back and will remain with my provider if he/she accessed such information before this Opt-Out went into effect; and
6. This request, and any future request to Opt In, can take up to 2 business days after receipt to take effect.

If this form is signed by someone other than the person named below, the person signing the form hereby certifies that he/she is acting as: (CHECK ONE) \_\_\_ Parent \_\_\_ Legal Guardian \_\_\_ Other (Specify Relationship) \_\_\_\_\_ for the person named below.

Contact Information for Individual Completing This Form If Other Than Patient (Please Print Clearly)\*

\_\_\_\_\_  
Printed Name \_\_\_\_\_  
Phone Number

Patient Name (Last) *	(First) *	(MI)
Previous Names or Nicknames	Patient Date of Birth *	Primary Number *
Email	Sex (M/F) *	( ) -
Address (Mailing) *	(City) *	Secondary Number
		( ) -
		(State) *      (Zip) *

\* required

\_\_\_\_\_  
**Signature of Patient** (or Authorized Representative) \_\_\_\_\_  
**Date Signed**  
If under 18 years, signature of parent of guardian

Please submit your form by: emailing it to [hie@ak-ehealth.org](mailto:hie@ak-ehealth.org); fax your completed form to 907-770-1413; or mail your completed form to AeHN, 2440 E. Tudor Rd, PMB 1143, Anchorage, AK 99507.