Providence St. Joseph Health

Revocation of HIE Opt-Out Request Form

This form is to be used by patients who wish to **revoke** a prior Opt Out form.

Providence St. Joseph Health's Health Information Exchange ("PSJH HIE") is a way of allowing your health information to be shared by participating medical groups, hospitals, labs, radiology centers, and other health care providers through secure, electronic means. The purpose of the PSJH HIE is to give each of your participating providers the benefit of having access to all of your health information that is maintained by the participating providers when providing healthcare to you. Your participation in the HIE is voluntary and you previously exercised your right to opt out of the PSJH HIE.

By signing this form, I hereby ACKNOWLEDGE and AGREE as follows:

1. I previously exercised my right to opt out of the PSJH HIE, but have changed my mind and would like to revoke my prior decision. I would now like my health information to be shared through the PSJH HIE to all health care providers involved in my care who participate in or are connected to the PSJH HIE.

2. I understand that by signing this form all of my health information from both before and after today's date will be shared through the PSJH HIE.

3. I understand that my decision to permit my health information to be shared through the PSJH HIE may be canceled again at any time by submitting a new completed "Providence St Joseph Health's Health Information Exchange HIE Opt Out Request Form" to Providence St. Joseph Health Information Exchange Department at the address provided at the bottom of this form;

4. It may take between **2 - 5 business days after receipt** to process my request to permit my health information to be shared through the PSJH HIE.

Please select one*: I am the Patient I am the Legal Representative of the Patient

Patient's Name: Last *	First*	Middle Initial
Previous Name or Nicknames:	Patient's Date of Birth:*	Primary Phone Number: *
Email:	Sex (M/F):	Secondary Phone Number:
Postal Address:*	City:*	State:* Zip:*

*required information

Signature of Patient (or Authorized Representative)
If under 18 years, signature of Parent or Guardian

Date Signed

Legal Representative Name *

Legal Representative Relationship to Patient*

Legal Representative Phone Number *

Mail:
PSJH Health Information Exchange (HIE) Division
c/o: Director of Health Information Exchange (HIE)
1515 E Orangewood Ave, Anaheim, CA 92805

Contact Us:
Tel: (833) 990-1900 or (714) 937 - 6249
Fax: (714) 935-1408
Email: HIEConsent@stjoe.org
WEBSITE: http://www.stjhs.org/hie