Providence St. Joseph Health

Revocation of Clinical Data Exchange Services 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 Clinical Data Exchange ("PSJH Clinical Data Exchange") services provide 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 PSJH Clinical Data Exchange is to give each of your participating providers the benefit of having access to all of your health information that is maintained by participating providers when providing healthcare to you. Your participation in Clinical Data Exchange is voluntary and you previously exercised your right to opt-out of PSJH Clinical Data Exchange services.

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

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

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 PSJH Clinical Data Exchange services.

3. I understand that my decision to permit my health information to be shared through PSJH Clinical Data Exchange services may be canceled again at any time by submitting a new completed **Clinical Data Exchange Services 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 Clinical Data Exchange.

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) **Date Signed**
If under 18 years, signature of Parent or Guardian

_____ _____ _____

Legal Representative Name * Legal Representative Relationship to Patient* Legal Representative Phone Number *

Mail:
PSJH Clinical Data Exchange
3345 Michelson Dr, Suite 100
Irvine, CA 92612

Contact Us:
Tel: (833) 990-1900 or (714) 937-6249
Fax: (844) 983-0648 or (714) 935-1408
Email: DataExchange@stjoe.org
WEBSITE: www.ProvShare.org