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 ("SJH 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 SJH 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 SJH HIE.

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

1. I previously exercised my right to opt-out of the SJH 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 SJH HIE to all health care providers involved in my care who participate in or are connected to the SJH 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 SJH HIE.

3. I understand that my decision to permit my health information to be shared through the SJH 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 the address provided at the bottom of this form or to Admissions, Registration or Front Office staff at a Providence St. Joseph Health facility;

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 SJH HIE.

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 *
Phone Number *

Legal Representative Relationship to Patient*

Legal Representative

&ÊÌÌ ÏÕÔ ÁÎÄ ÒÅÔÕÒÎ ÆÏÒ Í ÔÏ **Providence 3Ô8 *ÏÓÅÐÈ**
(ÅÁÌÔÈ 6ÉÁ¿ &ÁØT% Í ÁÊÌ7 - ÁÊÌ
Mail: SJH Health Information Exchange (HIE) Division
c/o: Director of Health Information Exchange (HIE)
1515 E Orangewood Ave, Anaheim, CA 92805

Contact Us:
Tel(844) 256 -4HIE(4443) or (714) 937-7000
Fax (714) 935-1407
Email @ HIE@stjoe.org
WEBSITE: @ http://www.stjhs.org/hie