Revocation of HIE Opt-In Consent Form

CovenantHealth

This form is to be used by patients who wish to **revoke** a prior HIE Opt-In Consent 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-in to the PSJH HIE.

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

1. I previously exercised my right to opt-in to the PSJH HIE, but have changed my mind and would like to revoke my prior decision. I request that my health information no longer 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. This will include in emergency care situations.
2. Even if I cancel my Opt-In consent by signing this form, information related to care that I have received at a Providence St. Joseph Health System, Covenant Health System, or Hoag Hospital facility will remain accessible through the PSJH HIE for treatment purposes to all participating providers who provide me with care; however, such information will not otherwise be disclosed by the PSJH HIE and no health information from my other providers will be accessible through the PSJH HIE. I understand that depending on the technical capabilities of my health care providers, even if I sign this form, my health information may still be disclosed by my provider to the PSJH HIE, but the PSJH HIE will not permit such health information to be viewed, except as described above related to hospital health information.
3. This revocation of Opt-In consent only applies to the sharing of health information through the PSJH HIE, and my health care providers may have access to my health information using other methods, such as by fax, telephone, email, or mail.
4. I may choose to opt back into the PSJH HIE at any time so that my health information may be shared through the PSJH HIE. To opt back into the PSJH HIE, I must submit a completed Providence St. Joseph Health "HIE Opt-In Consent Form" to Providence St. Joseph Health.
5. I understand that any information that was shared through the PSJH HIE before the date this form is processed may remain with the providers who accessed such information.
6. It may take between **2 - 5 business days after receipt** to process my request to prevent the sharing of my health information 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
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WEBSITE: http://www.stjhs.org/hie

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COVENANT HEALTH SYSTEM
LUBBOCK, TEXAS
REVOCATION OF HIE OPT IN CONSENT

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