3607

HEALTH INFORMATION EXCHANGE (HIE)
"ELECTRONIC NETWORK" OPT-OUT REQUEST FORM

Patient Information

Patient Name (First, Middle, Last): _____

Previous Names: _____ Date of Birth: (mm/dd/yyyy) _____

Mailing Address: _____

Contact Phone Number: _____

Loma Linda University Health, Loma Linda University, Loma Linda University Medical Center, Loma Linda University Children's Hospital, Loma Linda University Health System, and Loma Linda University Medical Center - Murrieta (LLUH) strives to provide excellence in healthcare. As part of this endeavor, LLUH now participates in a centralized healthcare information exchange between participating providers by means of a secure Electronic Network program. This Electronic Network program allows participating healthcare providers such as doctors, hospitals and other caregivers to share and access important health information they need to make informed decisions about your care, especially in an emergency.

Participating in the Electronic Network program is voluntary. You may at your discretion, 'opt-out' of having your healthcare information available to your health care providers outside of LLUH, that are participating in the Electronic Network program by submitting this completed form to LLUH. By opting out of participating in the Electronic Network program, please note that your participating providers will not be able to access your health information through the Electronic Network while providing care to you at another location outside LLUH, even during emergencies. The standard methods of information exchange between LLUH and your healthcare providers will continue to be available and ordering providers will continue to receive labs and test results for encounters in which they are listed as the ordering provider or on which they were copied.

Your decision whether or not to participate or opt-out from the Electronic Network program will not affect your ongoing medical care/relationship with your doctors and it will not involve any penalty or loss of benefits to which you are otherwise entitled.

By completing and signing this form, you are indicating that you would like to opt-out from having your healthcare information shared with the Electronic Network (Health Information Exchange).

1. I wish to opt-out of the Electronic Network. I understand that by making this selection, my health information will not be made available to any of my health care providers outside LLUH through the Electronic Network program, even in cases of medical emergency.

2. I understand that my opting-out of the Electronic Network does not affect the sharing of my health information within LLUH organizations listed in the Notice of Privacy Practices. Opting-out of this program only limits the ability of health care providers that are not affiliated with Loma Linda University Health to access my health information through this program.

3. I understand that my opting-out of the Electronic Network only applies to sharing my health information through this program. I understand that health care providers not affiliated with LLUH may request and receive my medical information using other methods permitted by law as needed for treatment purposes.

4. I understand that my selection to opt-out of the Electronic Network will remain in effect until and unless I revoke my selection in writing by completing the corresponding 'Revocation of Opt-Out Consent' form.

5. I understand that my health information that has been already accessed by my health care provider outside LLUH prior to my submission of this 'Opt-out' form cannot be retracted.

6. I understand that my selection to opt-out of the Electronic Network program may take up to 2 (two) business days to be processed.

By signing below you indicate that you have read, understand and agree to each of the above statements.

_____ _____

Patient Signature / Authorized Representative Date Signed

_____

Print Name

If this form is signed by someone other than the patient, the person signing the form hereby certifies that he/she is acting as the patient's (check one):

___Parent ___Legal Guardian ___ Other (please specify) _____

Additional information about the program, opting-out or opting-in is available by calling (909) 651-4191

FAX COMPLETED FORM TO (909) 651-4180