# HEALTH INFORMATION EXCHANGE (HIE) OPT-OUT FORM

CyncHealth is a Health Information Exchange ("HIE"). HIE is the electronic sharing of health information across other organizations. Exchanging information electronically is a faster way to share your health information with healthcare providers treating you. For example, if you go to a hospital emergency room that participates in these networks, the emergency room physicians would be able to access your electronic health information to help make treatment decisions for you. The HIE and these organizations are required to meet the rules that protect the privacy and security of your health and personal information. If you have paid for a healthcare service entirely out of pocket and requested your healthcare providers not disclose information relating solely to that service, it is the responsibility of the healthcare providers not to share that information unless the disclosure is required by law.

If you do **not** want your health information shared through these HIE exchanges, please complete this form.

**By signing this form, I hereby acknowledge and agree as follows:**

1. I request that my health information no longer be shared through the Health Information Exchange to all healthcare providers involved in my care who participate in or are connected to the HIE. This includes emergency care situations.
2. Opting out will remove your information from viewing by providers participating in the HIE except for your name, address, and opt-out status. It will not affect what your doctors have access to in electronic medical records on their system, and it will not be a condition to receiving care
3. Opting out does not preclude any participating organization that has received or accessed personal health information via the HIE prior to such opt-out, and incorporated such personal health information into its records, from retaining such information in its records.
4. Your physician or other treating providers will still be able to select the HIE as a way to receive your lab results, radiology reports, and other data sent directly to them that they may have previously received by fax, mail, or other electronic communications.
5. If you opt-out, health plans will continue to have access to your health information as authorized under HIPAA including to fulfill coverage responsibilities, providing benefits under the plan, and providing reimbursement for the provision of healthcare
6. I understand that this revocation only applies to the sharing of health information through the HIE. This does not include the prescription drug monitoring program, requests for paper records, public health, or other disclosures authorized by applicable law.
7. A request to opt out of the HIE will be effective within 30 days after receipt by CyncHealth of my completed request to prevent the sharing of my health information through the HIE.
8. I may choose to opt back into the HIE at any time so that my health information may be shared through HIE exchanges, if applicable.

- **Instructions:** In order to submit your request, please first print and complete this form. A contact phone number is required in case CyncHealth needs to contact you to ensure the accuracy of demographic information.

| Patient's Last Name: | Patient's First Name: | Middle Initial: | Previous Name or Nicknames: |
|---|---|---|---|
| Email Address | Patient's Date of Birth: | Primary Phone Number: | |
| Postal Address: | City: | State: Zip: | |

**For your protection, CyncHealth requires that your identity be verified, and your signature witnessed by a Notary Public in order to process this request. This form must be returned to CyncHealth with original signatures in black or blue ink.**

Signature of Patient: ______________________________________________________________________Date:____________

*If Patient is under 18 years, the Signature of Parent or Guardian is required below:*

Parent or Guardian: ___________________________________ Relationship to Patient: _________________________________

Date:____________

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State of __________________________________ County of ___________________________________

The foregoing instrument was acknowledged before me this _______________ by _________________________________.

(date) (name of person acknowledged)

Notary Print Name: ________________________________________

Notary Signature: _________________________________________

Notary Stamp:

**Email the completed notarized form to support@cynchealth.org**

**Or mail the completed notarized form to:**

CyncHealth Privacy Office
P.O. Box 27842
Omaha, NE 68127

**STAFF USE ONLY**

Received by:

_____________________________________________________

*STAFF NAME AND DEPARTMENT*

Date: _____________________________