



## HEALTH INFORMATION EXCHANGE (HIE) OPT-OUT

Patient Name (First, Middle, Last) \_\_\_\_\_

Home Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Telephone Number \_\_\_\_\_

Email Address: \_\_\_\_\_

By signing below, I acknowledge and agree as follows:

1. I wish to opt-out of the HIE in which Elmora Hills Healthcare and Rehabilitation Center participates. I understand that by making this decision my health information will not be shared by Virtua through these HIE(s) to any HIE participants outside of Virtua involved in my care, even in cases of a medical emergency.
2. I understand that opting out of the HIE does not prohibit Elmora Hills Healthcare and Rehabilitation Center from sharing my information with others involved in my care, as permitted by law, by methods other than the HIE, such as by phone, fax, mail, secure email or other electronic communications.
3. I understand that this HIE Opt-Out Form only prohibits Elmora Hills Healthcare and Rehabilitation Center from sharing my health information through the HIE that -Elmora Hills Healthcare and Rehabilitation Center participates in. I understand that my non-Elmora Hills Healthcare and Rehabilitation Center health care providers may also participate in HIEs. If I wish to opt-out of HIEs my other health care providers participate in, I am responsible for contacting each of my other health care providers for information on how to opt-out.
4. I understand that this opt-out will remain in effect unless I choose to opt back in. I may opt back in at any time by completing Elmora Hills Healthcare and Rehabilitation Center *Cancellation of Health Information Exchange (HIE) Opt-Out Form* and submitting as indicated on the form.
5. This opt-out may take up to five (5) business days after receipt by Elmora Hills Healthcare and Rehabilitation Center to take effect.
6. This opt-out does not apply to any of your health information shared by Elmora Hills Healthcare and Rehabilitation Center through the HIEs before this opt-out takes effect.

\_\_\_\_\_  
Signature of Resident/Patient or Resident's/Patient's Legal Representative (as applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Resident/Patient's Legal Representative (Print)

\_\_\_\_\_  
Relationship to Resident/Patient or Statement of Authority to act on Resident/Patient's Behalf (e.g., health care representative under healthcare power of attorney/proxy, legal guardian, etc.)

**Please complete and submit this form in person to Elmora Hills Healthcare and Rehabilitation Center registration staff, or by mail to Elmora Hills Healthcare and Rehabilitation Center, Health Information Mgmt. Department, 225 West Jersey St. Elizabeth, NJ 07207**

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**For Facility Use Only:**  
Date Received: \_\_\_\_\_ Date Completed: \_\_\_\_\_ Initials: \_\_\_\_\_