Sanitas Medical Center

# HEALTH INFORMATION EXCHANGE OPT-OUT FORM

Health Information Exchanges (HIE) allow your medical information to be available and viewed electronically by your Sanitas provider and care team members. HIEs are designed to provide quick access to medical records to make treatment more effective and efficient. Your Sanitas provider and care team participate in HIEs which allows them to electronically access and use your protected health information, if needed, to provide treatment to you.

**Patient Information**

| | | |
|---|---|---|
| Last Name | First Name | Middle Name |
| Previous Name or Nickname | Date of Birth | Primary Phone Number |
| Address | City | State and Zip Code |

I and/or my legally authorized representative have considered whether to allow my information to be viewed in the HIEs and have decided to OPT-OUT and NOT allow information to be viewed in the HIEs in which Sanitas participates. My decision to complete this form will not have any effect on my treatment or care.

By choosing to opt-out of the HIEs, I hereby acknowledge and agree as follows:

- This revocation only applies to the sharing of health information through the HIEs. Healthcare providers may still have access to my health information using other methods such as fax, telephone or mail.
- By opting out of participation in the HIEs, my healthcare providers outside of Sanitas will NOT be able to search for my records through the HIEs while providing me with treatment.
- My decision to opt-out will remain in effect until I notify Sanitas that I wish to participate in the HIEs.
- This opt-out request may take up to ten (10) business days to take effect.
- Any information that is shared before I submit this HIE opt-out form may remain with providers who accessed this information before this opt-out went into effect.

If this form is signed by someone other than the person named above, the person signing this form certifies that they are acting as (check one) ☐ Parent, ☐ Legal Guardian or ☐ Healthcare Power of Attorney for the person named above.

By: _____

Printed Name: _____

Date: _____(MM)_____(DD)_____(YYYY)

Please return a copy of the completed form by:

- Mail: Sanitas Medical Center, Attention: Privacy Officer, 8400 NW 33rd Street, #201, Doral, FL 33122