DT884

Children's Healthcare of Atlanta

Name______________________________

Date of Birth______________________________

MRN#______________________________

Account/HAR#______________________________

PATIENT IDENTIFICATION

HEALTH INFORMATION EXCHANGE (HIE) OPT-OUT REQUEST FORM

What is a Health Information Exchange (HIE)?
A Health Information Exchange is a way of sharing your child's health information among participating hospitals, doctors' offices, labs, pharmacies, and other healthcare providers throughout Georgia (and eventually nationally) through secure electronic means.

Why use an HIE?
Through an HIE, each of your child's participating caregivers can see the most recent information available from other participating caregivers when taking care of your child. For example, if your child was in the hospital and the doctor performed tests, those test results would be available electronically to your child's pediatrician.

What happens if I opt out?
If you opt out using this form, doctors and nurses will not be able to search for your child's health information through the HIE when they treat him or her. Public health reporting required by law (such as the reporting of certain infectious diseases to public health officials) may still happen through an HIE even if you opt out.

I request that my child's health information ***not*** be viewable through any health information exchange (HIE) in which Children's Healthcare of Atlanta, Inc. ("Children's"), its Affiliates[1], or any of Children's electronic medical record system participating practices[2] (collectively, the "Children's EMR Entities") participates, now or in the future.

Please initial that you have read and understand each of the following statements:

________ I understand that by submitting this HIE Opt-Out Request Form, my child's health information will not be viewable by participating health care providers (including emergency room physicians) through any HIE in which the Children's EMR Entities participate. I understand that my child's health information may still be stored electronically by each participating provider and more specifically, shared among the Children's EMR Entities.

________ I understand it may take 3-5 business days for this opt-out request to take effect.

________ I understand that any information that is shared before this opt-out request takes affect may remain with providers who accessed the information.

________ I understand that I am free to opt back in at any time and can do so by completing the Revocation of Prior HIE Opt-Out Form that I can obtain by contacting the **Children's Privacy Office at 404-785-1516.**

________ I understand that when my child sees a health care provider for treatment, that provider may request and receive my child's medical information from other providers using other methods permitted by law, such as fax, mail, or secure message.

[1]Children's Affiliates are listed at www.choa.org/hie.
[2]Children's electronic medical record system participating practices are listed at www.choa.org/hie.

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HEALTH INFORMATION EXCHANGE (HIE) OPT-OUT REQUEST FORM

Name________________________________

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(A separate form must be filled out for each family member requesting to opt out. **All fields are required** for form to be processed. Phone number is required in case we need to contact you to ensure accuracy of information.)

Patient's First Name: ______________________________ **Patient's Middle Name:** ________________________

Patient's Last Name: ______________________________ **Date of Birth:** ________________ (MM/DD/YYYY)

Previous Name(s) or Nicknames: ______________________________________ **Gender:** ☐ Male ☐ Female

Street Address: ____________________________ **City:** ______________ **State:** ____ **Zip Code:** __________

Parent/Guardian's First Name and Middle Initial: ____

Parent/Guardian's Last Name: _________________________ **Phone:** ____________________________________

Street Address: ____________________________ **City:** ______________ **State:** ____ **Zip Code:** __________

Signature of Parent/Guardian **Relationship** **Date Signed**

If Patient is over 18 years, signature of Patient

Please send this completed form to Children's Healthcare of Atlanta, Attn: Compliance c/o Privacy Office, 1575 Northeast Expressway NE, Atlanta, GA 30329