

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 Royal Suites Healthcare and Rehabilitation participates. I understand that by making this decision my health information will not be shared by Royal Suites Healthcare and Rehabilitation through these HIE(s) to any HIE participants (outside of Royal Suites Healthcare and Rehabilitation) involved in my care, even in cases of a medical emergency.
2. I understand that opting out of the HIE does not prohibit Royal Suites Healthcare and Rehabilitation 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 Royal Suites Healthcare and Rehabilitation from sharing my health information through the HIE that -Royal Suites Healthcare and Rehabilitation participates in. I understand that my non-Royal Suites Healthcare and Rehabilitation 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 Royal Suites Healthcare and Rehabilitation *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 Royal Suites Healthcare and Rehabilitation to take effect.
6. This opt-out does not apply to any of your health information shared by Royal Suites Healthcare and Rehabilitation 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 Royal Suites Healthcare and Rehabilitation registration staff, or by mail to Royal Suites Healthcare and Rehabilitation, Health Information Mgmt. Department, 214 West Jimmie Leeds Rd. Galloway, NJ 08205

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For Facility Use Only:

Date Received: _____ Date Completed: _____ Initials: _____