



Jersey Health Connect – Health Information Exchange **Patient Opt-Out Form**

This form is to be used by patients who do not wish to participate in Jersey Health Connect Health Information Organization Exchange.

A Health Information Exchange or HIE, is a way of sharing your health information among participating doctors' offices, hospitals, labs, radiology centers, and other health care providers through secure, electronic means. The purpose is for participating caregivers to have the benefit of the recent information available from your other participating caregivers when taking care of you.

When you opt out of participation in the HIE, doctors and nurses will not be able to obtain your health information through the HIE to use while treating you. Your physician or other treating providers will still be able to select the HIE 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. Public health reporting where applicable, in accordance with law such as the reporting of infectious diseases to public health officials, will also occur through the HIE after you decide to opt out.

If you do not live in New Jersey but still receive care in New Jersey, you should complete this form to opt out. If you wish to reverse your decision you may opt back in at any time.

Please note: Opt-out requests will be processed within five (5) business days.

There are two ways to submit your Opt-out request:

(1) by emailing your completed form to jennifer.dangelo@jerseyhealthconnect.org

or

(2) by mailing your completed form via certified mail to:

Jersey Health Connect
211 Warren Street
Newark, NJ 07103

Information for Patient Opting Out (Please PRINT Clearly)

Hospital Name _____

Patient First Name* _____

Patient Middle Name _____

Patient Last Name* _____

Address Line 1* _____

Address Line 2 _____

City* _____

State* _____

Zip Code* _____

Primary Phone Number* _____

Secondary Phone Number _____

Email _____

Date of Birth* _____

Sex (M/F)* _____

Reason for Opting Out (optional): _____

If this form is signed by someone other than the person named above, the person signing the form hereby certifies that he/she is acting as (CHECK ONE):

Parent: _____ Guardian: _____ Other (specify relationship): _____

Contact information for the individual completing this form if other than patient (please print CLEARLY):

Printed name: _____ Phone number: _____

Patient Information (please print CLEARLY) *

Printed Name: _____ Date: _____

Signature: _____