OPT-OUT CHANGE FORM

Name: _____

Date of Birth: ____/_____/_____

Address Street: _____

City: _____State: _____ Zip: _____

Phone: _____ e-mail: _____

I hereby acknowledge and agree as follows:

1. I WISH TO change my prior decision to Opt-Out of the Electronic Health Record (EHR) Exchange, and now **specifically AUTHORIZE** my health information to be electronically available to my providers participating in EHR Exchange;

2. I UNDERSTAND that by making this selection, ALL of my providers who participate in EHR Exchange will have electronic access to health information needed to coordinate my care;

3. I UNDERSTAND that by making this selection, my health information may be accessible by other connected Health Information Exchanges that utilize EHR Exchange to connect with my providers.

4. I UNDERSTAND that this selection can only be changed if I specifically submit a new HIE Opt-Out form;

5. I have had an opportunity to have all my questions regarding this "Opt-Out Change Form" answered; and

6. This request may take up to **2 business days** to take effect.

Signature: _____ Date:_____
Patient or Legal Representative

If Legal Representative, print name and state authority: Name: _____

Authority: _____

Completed and signed Opt-Out Change Form can be returned only to a participating provider location

For Vidant Health Facilities, the Opt-Out Change Form can be mailed to:

Vidant Medical Center
Health Information Management Services
2300 Beasley Drive
Doctors Park #8
Greenville, NC 27834