



CANCELLATION OF 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 cancel my previous decision to opt-out of the HIE in which Hunterdon Care Center participates. I understand that by making this decision I am authorizing my health information to be shared by Hunterdon Care Center through this HIE.
2. I understand that the information shared by Hunterdon Care Center may include information of a more sensitive nature, including but not limited to: genetic diseases or tests, substance use disorder, mental health conditions, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), sexually transmitted diseases (STDs), and birth control and abortion (family planning).
3. I understand that if I change my mind after opting back in, I may at any time later opt back out of the HIE in which Hunterdon Care Center participates by completing and submitting a new *Health Information Exchange (HIE) Opt-Out Form* as indicated on the form.
4. This cancellation of opt-out request can take up to five (5) business days after receipt by Hunterdon Care Center to take effect.

Signature of Resident/Patient or Resident'/Patient's Legal Representative (as applicable)

Date

Name of Resident's/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 Hunterdon Care Center registration staff, or by mail to Hunterdon Care Center Information Management Department, 1 Leisure Court, Flemington, New Jersey 08822.

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For Facility Use Only:
Date Received: _____ Date Completed: _____ Initials: _____