OPT-OUT FORM

FOR ELECTRONIC HEALTH INFORMATION EXCHANGE

Deer Meadows
Home Health and Support Services, LLC

INSTRUCTIONS:

STEP 1—Please review the patient guide brochure prior to completing this form.

STEP 2—Complete **Section 1** to opt-out of electronic health information exchange. Please initial that you have read and understand each of the following statements in Section 1.

STEP 3—Please complete all of the remaining sections of the form and sign.

Section 1—To **opt-out** of the electronic health information exchange, please initial each below:

_________ By submitting this opt-out form, information about me **will not** be accessible to healthcare professionals and other authorized users (including emergency services) by use of the electronic health information exchange.

__________ This request does not prohibit my healthcare provider from otherwise disclosing my medical information pursuant to other authorizations and applicable laws, or by other methods, including fax.

__________ I may choose to participate in electronic health information exchange again at any time by submitting an opt-back-in form. Please see other side of this page.

Section 2—Please complete each area below:

First Name: ____

Last Name: ____

Date of Birth: _______/________/_________

By signing this form, I verify that I am the person named above, or that I am legally authorized to complete and sign this form for the person named above. The information provided on this form, and the preferences expressed herein, are true and correct to the best of my knowledge, information, and belief.

Patient Signature: ____ Date:____________________________

Guardian or Representative: _____________________________Relationship to Patient:______________________

Signature of patient, parent, legal guardian, or legal representative where required. If legal guardian or representative, please state your relationship to the patient.

OPT-BACK-IN FORM

Deer Meadows
Home Health and Support Services, LLC

FOR ELECTRONIC HEALTH INFORMATION EXCHANGE

INSTRUCTIONS:

STEP 1—Please review the patient guide brochure prior to completing this form.

STEP 2—Complete **Section 1** to opt back into electronic health information exchange. Please initial that you have read and understand the following statement in Section 1.

STEP 3—Please complete all of the remaining sections of the form and sign.

Section 1—To **opt back into** electronic health information exchange, please initial each below:

_________ By completing this section, information about me (including information created prior to today's date) **will** be accessible to healthcare professionals and other authorized users (including emergency services) by use of the electronic health information exchange.

Section 2—Please complete each area below:

First Name: ____

Last Name: ____

Date of Birth: _______/________/_________

By signing this form, I verify that I am the person named above, or that I am legally authorized to complete and sign this form for the person named above. The information provided on this form, and the preferences expressed herein, are true and correct to the best of my knowledge, information, and belief.

Patient Signature: ____ Date:___________________________

Guardian or Representative: ____________________________Relationship to Patient:_____________________

Signature of patient, parent, legal guardian, or legal representative where required. If legal guardian or representative, please state your relationship to the patient.