healthcurrent

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OPT OUT CHANGE FORM

Please complete and return this form to your healthcare provider who will fax/email this form to Health Current, Arizona's health information exchange (HIE).

Please check the box next to your choice regarding the secure sharing of your health information among your health care providers. Be sure to sign the form at the end. Each family member should fill out and submit a separate form.

☐ **Choice 1:** I do not agree to have my medical information securely shared among my health care providers. I understand and accept the risks associated with denying any access by anyone under any circumstances including medical emergencies

☐ **Choice 2:** I agree to have my information shared among my health care providers EXCEPT information from the health care provider(s) listed below. This means others will not see information about me from this health care provider. Caution: If that provider works for an organization (like a hospital or a group of physicians), all your information from that hospital or group of physicians may be blocked from view.

You must provide the full name, address and phone number of each health care provider you wish to exclude from sharing your health information. Incomplete information cannot be implemented. Submit one form for each provider.

Health Care Provider Full Name	Address	Phone Number

Signature:_____

Print Full Name:_____Date:_____

Date of Birth:_____Patient ID/MRN:_____

Complete this section only if you are signing the form for another person.

Please indicate the authority you have to make health care decisions on behalf of the patient.

☐ Spouse ☐ Parent/Guardian ☐ Caregiver

Signature:_____Date:_____

Print Full Name: _____

Address:_____City:_____State:_____Zip:_____

Provider Office Only: *please complete before sending via secure fax to Health Current, formerly Arizona Health-e Connection.*

Print Name:_____Date:_____

Signature:_____