KAISER PERMANENTE® *HAWAII REGION*

Health Information Exchange Opt Out Request Form

Original: 07/31/13 Revised:

MR#:

Name:

Sex/BD:

Health Information Exchange (HIE) is the sharing of health information electronically across organizations. Kaiser Permanente (KP) operates an HIE Network among KP regions, participates in several HIE networks with other health care providers outside of KP, and may share your health information electronically with other organizations such as public health departments and health plans. Exchanging information electronically is a faster way to share your health information with health care providers treating you. For example, if you go to a hospital emergency room that participates in the same HIE network as KP, the emergency room physicians would be able to access your KP health information to help make treatment decisions for you. HIE participants like KP are required to meet rules that protect the privacy and security of your health and personal information.

If you do not want KP to share your health information through an HIE network, please complete this form and return it to the address below. By completing this form, you request and understand that:

- KP-Hawaii Region will not share your health information electronically through an HIE with any other KP regions or outside organizations, except that public health reporting through an HIE, in accordance with laws such as the reporting of infectious diseases, will not be affected by this opt-out.
- You cannot choose to participate in one HIE and not another, or request that one type of health information be exchanged and not another.
- Providers outside of Kaiser Permanente – Hawaii Region can still request and receive your medical information from KP through other methods, such as fax or mail.

A request to opt out of an HIE will be effective approximately five (5) days after receipt by Kaiser Permanente, and will not apply to any information sent through the HIE or exchanged with other participants in an HIE network before that date. You are free to opt back in at any time by completing an Opt-In Request Form that can be obtained from Customer Service or downloaded from kp.org.

A separate form must be completed by each family member wishing to Opt Out. Please complete all of the below required fields for accurate processing. Print legibly with a black ball point pen.

Patient Name *(print)*	**Health Record #**	**Date of Birth**	**Mailing Address**	**Telephone #**

X **Signature (Required)** _____ **Date** ___ | ___ | _____

If signed by someone other than the patient, please print name below and indicate relationship. Submit documents to show authority.

Print Authorized Representative's Name _____ Relationship to patient

Once this form is complete, please mail to:

Kaiser Permanente
Patient Identity Administration
501 Alakawa Street
Honolulu, HI 96817

For Kaiser Use Only:

1. Print Staff Name: _____
2. Dept: _____ Ph#: _____
3. Date Received: ____ | ____ | _____

Patient ID Use Only:

Staff Name:

Date Implemented: