Capital Health

Health Information Exchanges
Cancellation of Prior Opt Out

Patient First Name _____
Patient Middle Name _____
Patient Last Name _____
Address Line 1 _____
Address Line 2 _____
City, State, Zip Code _____
Primary Phone Number _____
Secondary Phone Number _____
Email _____
Date of Birth _____
Sex (M/F) _____

I hereby acknowledge and agree as follows:

1. I WISH TO cancel my prior decision to Opt-Out of all of the Health Information Exchanges (HIE) in use at Capital Health, including but not limited to, CommonWell and the Trenton Health Information Exchange, and now I specifically AUTHORIZE my health information maintained in the HIEs referenced above to be electronically available to my provider(s).
2. I UNDERSTAND that by making this selection, now ALL of my authorized providers who are connected to or participate in the Health Information Exchanges in use at Capital Health, including but not limited to, CommonWell and the Trenton Health Information Exchange will have access to my health information maintained in the HIEs referenced above.
3. I UNDERSTAND that by making this selection, my health information may be accessible by other HIEs, including but not limited to, with whom the CommonWell HIE and Trenton HIE participate.
4. I UNDERSTAND that this cancellation can only be changed if I specifically submit a new Opt-Out Form.
5. I have had an opportunity to have all my questions regarding this "Cancellation of All Health Information Exchanges Opt-Out" and others answered.
6. All efforts will be made to process this request within ten (10) business days.

If this form is signed by someone other than the person named above, the person signing the form hereby certifies that they are acting as: (CHECK ONE) ___ Parent ___ Legal Guardian
___ Other (Specify Relationship) _____ for the person named above.

Contact Information for Individual Completing This Form If Other Than Patient (Please Print Clearly)
Printed Name_____ Phone Number_____

Patient Information (Please Print Clearly)
Printed Name_____ Signature_____
Date_____

**********Internal Usage**********

Date Completed: _____ Processed By (Name):_____

Mail your completed form to:
Capital Health
One Capital Way
Pennington, NJ 08534
Attn: Health Information Management

Or Fax your completed form to:
1-609-303-4093