SacValley MedShare

The Health Information Exchange for California's North Central Valley

MR#: ____________ **Patient Name:** ____________________ **DOB:** ____________

Health Information Exchange (HIE) is the sharing of health information electronically across organizations. SacValley MedShare (SVMS) operates an HIE Network among SVMS regions and participates in several HIE networks with other health care providers outside of SVMS and may share your health information electronically with other organizations such as public health departments, health plans, health care providers, and other participants. 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 SVMS, the emergency room physicians would be able to access your SVMS health information to help make treatment decisions for you. HIE participants like SVMS are required to meet rules that protect the privacy and security of your health and personal information.

If you do not want your health information shared through an HIE network, please complete this form and return it to the address below. By completing this form, you request that SVMS not share your health information electronically through Health Information Exchange with any other regions or outside organizations. At this time, if you decide to Opt Out of exchanging your information, none of your information will be shared through a SVMS HIE network., even in an emergency. In other words, opting out is an all "all or nothing" concept. A request to opt out of an HIE will be effective approximately five (5) business days after receipt by SVMS, 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-Out Revocation Form that can be obtained from Membership Services or downloaded from http://sacvalleyms.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.

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Health Information Exchange Opt-Out Request

MR#: ____________ **Patient Name:** ____________________ **DOB:** ____________

First Name MI Last Name DOB

____ ______________

Mailing Address (Street Address, City, State, Zip Code)

____

Telephone Number Medical Record Number

________________ ________________________

Signature (Required) Date

____

Print Authorized Representative's Name Relationship to Patient

____

Please Mail Completed Form To:

SacValley MedShare, 1448 Esplanade, Chico CA 95926