RI HIE Patient Opt-Out Form

RHODE ISLAND HIE

This form is to be used by patients who do not wish to participate in RI HIE, Rhode Island's statewide Health Information Exchange (HIE).

Health Information Exchange, or HIE, is a way of sharing your health information among participating doctors' offices, hospitals, care coordinators, labs, radiology centers, and other health care providers through secure, electronic means. The purpose is so that each of your participating healthcare providers can have the benefit of the most recent information available from your other participating providers when taking care of you. When you opt out of participation in the HIE, doctors and nurses will not be able to search for your health information through the HIE to use while treating you.

Exclusions:

In accordance with the law, the following are excluded from your opt-out request:

- Public Health reporting, such as the reporting of infectious diseases to public health officials
- Temporary access to health information in the event of an emergency
- Health plans where information is necessary for care management, quality, and performance measure reporting

You have several options for opting out of RI HIE. Please complete one option:

1. **Fill out an electronic form by visiting RIHIE.org** (preferred)
2. **Print and complete the Patient Opt-Out Form**
   a. **Mail to: PO Box 1152, Columbia, MD 21044-9997**
   b. **Email: support@rihie.org**
3. **Call 866-957-4254** to speak to Technical User Support who will assist you.

Note: *If you are someone who makes healthcare decisions for a patient and are requesting to opt out of RI HIE for that person, you must attest to your relationship to that person on the form.*

This Opt-Out Form only needs to be completed once to opt out of the HIE; it is not necessary to complete for each provider. The effective date will be the date the request is received and recorded in the RI HIE health information exchange system and will not affect previous disclosures or access to your health information.

If you wish to reverse your decision, you may opt back in at any time by calling RI HIE at **866-957-4254**.

For more information about health information exchange and your rights, please visit **RIHIE.org** or call Customer Service at **866-957-4254**.

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(= Required)*

First Name*: Add your name

Middle Name: Add your middle name

Last Name*: Add your last name

Email: add your name

Primary Phone Number*: Phone number #1

Secondary Phone Number: Phone number #2

Date of Birth*: Add your date of birth

Sex*: *(select one)* ☐ **Male** ☐ **Female** ☐ **Other / Do Not Wish to Disclouse**

Address Line 1*: Address #1

Address Line 2: Address #2

City*: Add your city

State*: Add your state

Zip*: Add your zip code

☐ **Opt Out of All Sharing** – Opt out of all sharing of your information through health information exchange, except for the exclusions noted above.

If this form is submitted by someone other than the person named above, the person submitting the form hereby certifies that he/she is acting as (CHECK ONE & complete contact information):

☐ **Parent**

Name of Person Submitting Form*: Name

Phone # of Person Submitting Form*: Phone

☐ **Legal Guardian**

Name of Person Submitting Form*: Name

Phone # of Person Submitting Form*: Phone

☐ **Other**

Name of Person Submitting Form*: Name

Phone # of Person Submitting Form*: Phone

Please specify relationship to the person named above*: Relationship

I would like to be notified of my participation choice in the following way (choose one): ☐ Email ☐ Phone ☐ Text ☐ No Notification

I understand that falsifying my identity or signing on behalf of an individual in which I do not have authority is against the law and a punishable offense. For more information, please contact RI HIE at **866-957-4254**.