HIE OPT-OUT FORM

TRINITY HEALTH

This form is to be used by patients who **do not** wish to participate in the Health Information Exchange (HIE)

Trinity Health participates in a Health Information Exchange ("HIE") which allows you to permit your health information to be shared by participating medical groups, hospitals, labs, radiology centers, and other health care providers through secure, electronic means. The purpose of the HIE is to give each of your participating providers the benefit of having access to all of your health information that is maintained by the participating providers when providing healthcare to you.

Your participation in the HIE is voluntary and subject to your right to opt-out. Your receipt of treatment or health plan coverage for treatment will not be conditioned on whether or not you choose to exercise this right.

Unless you opt-out, any authorized healthcare provider who participates with the HIE, or is a member of a health information exchange that is connected to the HIE, can electronically access and share your health information through the HIE as set forth below.

- The health information that will be shared through the HIE will include health information from both before and after today's date and may include information related to treatment you received from any provider who is connected, either directly or indirectly, to the HIE, including out-of- state providers.
- The health information that will be shared through the HIE includes information about your diagnoses, test results (like X-rays or laboratory), and medications that have been prescribed to you. Such information may also include health information that may be considered particularly sensitive to you, including: mental health information; HIV/AIDs information and test results; genetic information and test results; STD treatment and test results, and family planning information.
- The health information that is made available to the HIE may be used by HIE participants for treatment purposes. The HIE may further use your health information and make it available to other health information exchanges and their participants, for treatment, payment, and health care operations activities; however, such disclosures by the HIE to another health information exchange will only be permitted in accordance with applicable law and information that is disclosed will not include HIV test results, mental/behavioral health records, and genetic/hereditary test results.

By signing this form, I hereby ACKNOWLEDGE and AGREE as follows:

1. I am requesting that none of my health information be shared through the HIE.

2. Even if I Opt-Out by signing this form, information related to care that I have received at a Trinity Health facility will remain accessible through the HIE for treatment purposes to all participating providers who provide me with care; however, such information will not otherwise be disclosed by the HIE and no health information from my other providers will be accessible through the HIE. I understand that depending on the technical capabilities of my health care providers, even if I sign this form, my health information may still be disclosed by my provider to the HIE, but the HIE will not permit such health information to be viewed, except as described above related to hospital health information.

3. This Opt-Out request only applies to the sharing of health information through the HIE, and my health care providers may have access to my health information using other methods, such as by fax, telephone, email, or mail.

4. I may choose to opt back into the HIE at any time so that my health information may be shared through the HIE. To opt back into the HIE, I must submit a completed "Health Information Exchange Revocation of Opt-Out Request Form" to the address provided at the bottom of this form or to Admissions, Registration or Front Office staff at a Trinity Health facility.

LEG14

PATIENT LABEL
OR

PATIENT NAME:_____

PATIENT DOB:_____

5. I understand that any information that was shared through the HIE before the date this form is processed may remain with the providers who accessed such information.

6. It may take between 2 - 5 business days after receipt to process this Opt-out form and to prevent the sharing of my health information through the HIE.

7. Many North Dakota Providers, like Trinity, also participate in the North Dakota Health Information Network ("NDHIN"). If you wish to opt-out of the NDHIN, you will need to contact them directly at: https://www.nd.gov/itd/statewide-alliances/ndhin or (855) 761-0534

Patient's Name: Last *	First*	Middle Initial
Previous Name or Nicknames:	Patient's Date of Birth:* ( )	Primary Phone Number: * -
Email:	Sex (M/F):*	Secondary Phone Number: ( ) -
Postal Address:*	City:*	State:* Zip:*

*required information

Signature of Patient (or Legal Representative)
If under 18 years, signature of Parent or Guardian

Date Signed

Legal Representative Name *

Legal Representative Relationship to Patient*

Legal Representative

Fill out and return form to Trinity Health:
At the Hospital/Medical Office: Admissions/Registration/Front Office
(SCAN TO PATIENT RECORD)

Contact Us:
Tel (701) 858-6455
Fax (701) 857-5165

Mail: Health Information Exchange (HIE)
c/o: Information Security Officer

PO Box 5020 Minot, ND 58702