Patient Name:			Birth Date:	
treet Address:		Telephone No.:		
City:	State:	Zip Code:	Last 4 SSN:	Gender:

By signing this form, I am acknowledging that I would like to opt out of participating in the Baptist ConnectSM Private Health Information Exchange and the First Coast Health Alliance Private Health Information Exchange. I understand I will be excluded completely from both PHIE's with respect to all participating providers and will assume the risk that my denial may prevent my physicians and other participating providers from having a complete picture of my health. Note that "Opting out" does not limit any sharing of your medical information otherwise permitted without your consent by HIPAA or applicable State law, including in an emergency situation, and will not affect any previous exchange of my medical information.

Signature of Patient

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If the patient is (i) a minor, the patient's parent or guardian should consent by signing below, or (ii) an adult but mentally or physically unable to consent for himself or herself, then the patient's guardian, legal representative, attorney-in-fact, surrogate or proxy should consent on the patient's behalf by signing below:

Date

Time

Signature of Representative Printed Name		Date	Time Telephone	
		Relationship to Patient		
	HIM Use Only			
Entered By		Date	Time	
Signature		Date	Time	
	Return completed form v e-mail to: BaptistHIEConsent@b OR Mail to: Baptist Medical Center-J ATTN: HIM 800 Prudential Drive, Jacksonville, I Phone: 904.202.1347	mcjax.com acksonville		
Baptist Medical Center Jacksonville, Jacksonville, FL Baptist Medical Center Beaches, Jacksonville Beach, FL Baptist Medical Center Beaches, Jacksonville, Beach, FL Baptist Medical Center South, Jacksonville, FL Baptist Emergency Center, Jacksonville, FL Baptist Emergency Town Center, Jacksonville, FL Baptist North Emergency Center, Jacksonville, FL Baptist North Emergency Center, Jacksonville, FL	BAPTIST CONNECT SM PRIVATE HEALTH INFORMATION EXCHANGES PATIENT ELECTRONIC HEALTH OPT OUT FORM	PATIEN	NT LABEL	