Iredell Memorial Hospital Health Information Exchange Opt Out Information

Updated 7/17/2019

CommonWell Health Alliance Information Exchange https://www.commonwellalliance.org. Iredell Memorial Hospital participates in the CommonWell Health Alliance Information Exchange. The CommonWell Health Alliance ("CommonWell") is an organization that was developed to support the ability of health technology systems to efficiently exchange information to improve patient care. You have the right to "opt-out" of CommonWell at any time. If you choose to opt-out, please be aware that this means some of your information may not be available to other providers through CommonWell in the event of a personal healthcare or local emergency. Your decision to opt-out will remain in effect until you notify Iredell Memorial Hospital that you would like to participate. This opt-out is only applicable to information subject to CommonWell and not to other uses and disclosures of your health information as described in this notice. We will still provide necessary health care services to you if you opt-out. To proceed with the opt-out process, complete the information on this form.

One Partner Health Information Exchange http://www.onepartner.com/hie. Iredell Memorial Hospital participates in the OnePartner Health Information Exchange (HIE). This means that we electronically share some of your health information with other HIE participants for treatment, payment, health care operations and other purposes permitted by law. We will not share substance use disorder information through the OnePartner HIE. You have the right to "opt-out" of the OnePartner HIE at any time. If you choose to opt-out, please be aware that this means some of your information may not be available to other providers through the OnePartner HIE in the event of a personal healthcare or local emergency. Your decision to opt-out will remain in effect until you notify Iredell Memorial Hospital that you would like to participate. This opt-out is only applicable to information subject to the OnePartner HIE and not to other uses and disclosures of your health information as described in this notice. We will still provide necessary health care services to you if you opt-out. To proceed with the opt-out process, complete the information on this form.

You can also use this form to rescind a previous opt out if you change your mind.

Iredell Memorial Hospital Health Information Exchange Opt Out Form

Please complete the form with the information requested below, and mail to:
IREDELL MEMORIAL HOSPITAL, Attn: Medical Records, 557 BROOKDALE DRIVE, STATESVILLE, NC 28677
Please include a return address on the mailing envelope.

___ **Opt Out: Iredell Memorial Hospital may not share any of my health information with the CommonWell Health Alliance Information Exchange.**

By completing and signing this form, I certify that I have been notified of the benefits of the CommonWell Health Alliance Information Exchange and of my right to opt out of having my data shared between Iredell Memorial Hospital and other health care providers that participate with the CommonWell Health Alliance Information Exchange. I understand that the information provided to me is not legal advice and I will hold Iredell Memorial Hospital harmless for the direct or indirect consequences of my decision to opt out.

___ **Opt Out: Iredell Memorial Hospital may not share any of my health information with the One Partner Health Information Exchange.**

By completing and signing this form, I certify that I have been notified of the benefits of the One Partner Health Information Exchange and of my right to opt out of having my data shared between Iredell Memorial Hospital and other health care providers that participate with the One Partner Health Information Exchange. I understand that the information provided to me is not legal advice and I will hold Iredell Memorial Hospital harmless for the direct or indirect consequences of my decision to opt out.

___ **Rescind Opt Out: I request to terminate my previous decision to opt out of CommonWell and OnePartner.**

By completing and signing this form, I am allowing my health information to be accessible to my healthcare providers that participate with either CommonWell or OnePartner as permitted by law.

_____ _____

Signature of Patient or Parent/Legal Guardian Date

_____

Print Name

_____

Please complete the following fields for the patient who is requesting the opt out or the opt out rescission. Incomplete forms will not be processed.

_____

First Name of Patient Middle Name Last Name

_____ _____

Street Address Mailing Address

_____ _____

City State ZIP City State ZIP

_____ _____ _____

Date of Birth Sex Email

(____)_____ (____)_____

Primary Phone Number Secondary Phone Number