



CANCELLATION OF HEALTH INFORMATION EXCHANGE (HIE) OPT-OUT

Patient Name (First, Middle, Last) _____

Home Address _____

Date of Birth _____ Telephone Number _____

Email Address: _____

By signing below, I acknowledge and agree as follows:

1. I wish to cancel my previous decision to opt-out of the HIE in which Atlantic Coast Rehabilitation and Healthcare Center participates. I understand that by making this decision I am authorizing my health information to be shared by Atlantic Coast Rehabilitation and Healthcare Center through this HIE.
2. I understand that the information shared by Atlantic Coast Rehabilitation and Healthcare Center may include information of a more sensitive nature, including but not limited to: genetic diseases or tests, substance use disorder, mental health conditions, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), sexually transmitted diseases (STDs), and birth control and abortion (family planning).
3. I understand that if I change my mind after opting back in, I may at any time later opt back out of the HIE in which Atlantic Coast Rehabilitation and Healthcare Center participates by completing and submitting a new *Health Information Exchange (HIE) Opt-Out Form* as indicated on the form.
4. This cancellation of opt-out request can take up to five (5) business days after receipt by Atlantic Coast Rehabilitation and Healthcare Center to take effect.

Signature of Resident/Patient or Resident'/Patient's Legal Representative (as applicable)

Date

Name of Resident's/Patient's Legal Representative (Print)

Relationship to Resident/Patient or Statement of Authority to act on Resident/Patient's Behalf (e.g., health care representative under healthcare power of attorney/proxy, legal guardian, etc.)

Please complete and submit this form in person to Atlantic Coast Rehabilitation and Healthcare Center registration staff, or by mail to Atlantic Coast Rehabilitation and Healthcare Center Information Management Department, 485 River Ave. Lakewood, NJ 08701

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For Facility Use Only:

Date Received: _____ Date Completed: _____ Initials: _____