ATLANTIC COAST
REHABILITATION & HEALTHCARE CENTER

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 opt-out of the HIE in which Atlantic Coast Rehabilitation and Healthcare Center participates. I understand that by making this decision my health information will not be shared by Virtua through these HIE(s)s to any HIE participants outside of Virtua involved in my care, even in cases of a medical emergency.
2. I understand that opting out of the HIE does not prohibit Atlantic Coast Rehabilitation and Healthcare Center from sharing my information with others involved in my care, as permitted by law, by methods other than the HIE, such as by phone, fax, mail, secure email or other electronic communications.
3. I understand that this HIE Opt-Out Form only prohibits Atlantic Coast Rehabilitation and Healthcare Center from sharing my health information through the HIE that -Atlantic Coast Rehabilitation and Healthcare Center participates in. I understand that my non-Atlantic Coast Rehabilitation and Healthcare Center health care providers may also participate in HIEs. If I wish to opt-out of HIEs my other health care providers participate in, I am responsible for contacting each of my other health care providers for information on how to opt-out.
4. I understand that this opt-out will remain in effect unless I choose to opt back in. I may opt back in at any time by completing Atlantic Coast Rehabilitation and Healthcare Center *Cancellation of Health Information Exchange (HIE) Opt-Out Form* and submitting as indicated on the form.
5. This opt-out may take up to five (5) business days after receipt by Atlantic Coast Rehabilitation and Healthcare Center to take effect.
6. This opt-out does not apply to any of your health information shared by Atlantic Coast Rehabilitation and Healthcare Center through the HIEs before this opt-out takes effect.

_____ _____

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

Date

_____ _____

Name of Resident/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, Health Information Mgmt. Department, 485 River Ave. Lakewood, NJ 08701

For Facility Use Only:
Date Received:_____Date Completed: _____ Initials: _____