Advocate Physician Partners

SynAPPS

Notificaton: Opting out of eEHX-

Electronic Health Information Exchange and/or Illinois' Immunization Registry

_____NO. I do not want my Health Information included in the electronic Health Information Exchange as described above.

I acknowledge that I have been given sufficient information and have had the opportunity to have my questions answered about the electronic Health Information Exchange.

I understand that I am withdrawing permission for sharing my Health Information by signing this notice and submitting it to the practice manager of my physician's office. Any withdrawal of permission will be effective except to the extent action already has been taken in reliance on this permission. This permission will expire if the electronic Health Information Exchange program is discontinued.

I understand that my eligibility for treatment or any healthcare benefits cannot be conditioned on whether I sign this permission. However, to the extent I have indicated "NO" to sharing of my Health Information, I understand that an electronic Health Information Exchange record will not be available to other providers.

_____ I request that my immunization information be removed from the Illinois Immunization Registry. I understand the state will not share immunization data on me from the registry as a result of this action. The registry will retain core demographic information necessary to identify that I have chosen to opt out of the registry. This information is necessary for the registry to be able to filter and refuse entry of immunization information for me. Additionally, any prior immunization records associated with me will not be shared from the registry. No immunization information will be added to the registry for me until the Illinois Immunization Program receives notification that I wish to opt back into the registry. To opt back in, a separate opt in form must be completed.

_____

Printed Name of Patient/Representative

_____ _____

Signature of Patient/Representative Date

AUTHORITY OF REPRESENTATIVE:

I, _____, do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis:

Relationship to Patient: _____

[A signed copy of this permission will be provided to the patient/representative. **Please place a copy of this form in the patient's medical chart.]**

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