GBMC
6701 North Charles Street
Baltimore, MD 21204

Request to Opt-Out of Health Information Exchange (HIE)

To opt-out complete and submit this form to the Health Information Management Department via e-mail (him@gbmc.org), fax (443-849-2276) or mail (GBMC HIM Department- Suite 3247 6701 North Charles Street Baltimore, MD 21204). The Health Information Management Department will provide you with written confirmation via mail that your opt-out request has been processed.

- I am signing this form because I do not want my health records shared with my non-GBMC providers and health care team members through the Health Information Exchanges (HIEs).
- ***By opting out of the Health Information Exchanges (HIEs), I deny my non-GBMC providers immediate access to critical information about my health through these HIEs. This may impact my provider's ability to see a complete picture of my health which could limit their ability to make the best possible decisions about my care.***
- My health records will be shared with the HIEs up to the date this is provided to and processed by HIM. GBMC cannot remove my health records from the HIEs prior to my opt-out request being processed.
- When I see a health care provider for treatment, that provider may request and receive my medical information from other providers using other methods permitted by law, such as fax or mail. I am aware that health care providers who originally recorded information about me may continue to have access to this information through means other than the HIE.
- I should discuss HIEs with my health care team at non-GBMC locations to determine their policies around exchanging information.
- Other networks may still share my information in accordance with federal and state law and for the purposes of continuation of care, payment for services, and other operations of my healthcare providers.
- I may opt-out to my health information being available through Chesapeake Regional Information System for our Patients, Inc. (CRISP) by calling 1-877-952-7477 or completing and submitting and Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org.

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Patient Name (Please Print) **DOB**

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Signature of Patient or Responsible Party **Date** **Time**