
**TRENTON HIE OPT-OUT FORM**

Name_____

Date of Birth: ____/____/_____

Street Address:_____

City:_____ State:_____ Zip: _____

Phone:_____ e-mail: _____

I hereby acknowledge and agree as follows:

1. I WISH to OPT OUT of the Trenton HIE. I understand that by making this selection, NONE of my health care providers will be able to access my health information maintained anywhere on the Trenton HIE, even in cases of a medical emergency:

2. I UNDERSTAND that my providers who originally generated information about me will continue to have access to my information, but only in the medical record that they created for me, or by obtaining it via previously established methods;

3. I UNDERSTAND that this HIE Opt-Out will NOT allow Trenton HIE to make my health information available to other connected HIEs, even in cases of a medical emergency:

4. I UNDERSTAND that this HIE Opt-Out does NOT cover or effectuate my opting-out of any other HIE. I UNDERSTAND that if I wish to opt-out of another HIE, I am responsible for approaching my provider participating in such other HIE(s) about how I can do that;

5. My HIE Opt-Out selection will remain in effect unless I change it in writing;

6. I UNDERSTAND that once this HIE Opt-Out goes into effect, I can change my mind only by submitting a Cancellation of Prior Trenton HIE Opt-Out form;

7. I have had an opportunity to have all my questions about this "HIE Opt- Out" and any others answered;

8. Any information that is disclosed before I submit this HIE Opt-Out cannot be taken back and will remain with my provider who may have accessed such information before this Opt-Out went into effect ; and

9. This request can take up to 2-3 business days to take effect.

Signature:_____ Date:_____

If Legal Rep, state Authority: _____

This completed and signed Trenton HIE Opt-Out form can be faxed to 609-256-4554 or mailed to:
Trenton HIE Administrator
c/o Trenton Health Team
218 North Broad Street
Trenton, NJ 08608