Children's Hospital of Philadelphia℠

ADM-126
Rev. 4/21

LAST NAME | FIRST NAME

MR# | DOB

PLACE PATIENT LABEL HERE *OR* COMPLETE ABOVE

DO NOT HANDWRITE PATIENT INFORMATION HERE

HEALTH INFORMATION EXCHANGE PATIENT OPT-OUT FORM

What are health information exchanges and why does Children's Hospital of Philadelphia (CHOP) share information with them?

A Health Information Exchange (HIE) is a way to share your/your child's medical information electronically with other healthcare providers that are not affiliated with CHOP for purposes of treatment, payment, and other purposes allowed by law. Among other things, HIEs allow us to quickly and securely share your/your child's medical information with other healthcare providers so that they can provide safer, more effective care. Your/your child's medical information from CHOP is automatically shared with HIEs that CHOP participates in unless you opt out. Please be aware that opting out of HIE data sharing with CHOP does not prevent other entities involved in your care or the care of your child from sharing information with CHOP.

How can I Opt-Out of HIE data sharing at CHOP?

If you do not want CHOP to electronically share health information your/your child's CHOP medical record through HIEs, then please complete and submit this form to opt-out. If you do so, CHOP will no longer share your/your child's information going forward through the HIEs that CHOP participates in. However, in order to promote safe and effective care, CHOP will continue to share information about your care or the care of your child with other providers involved in your/your child's care and with other recipients permitted to have such information through means such as by phone and fax.

To opt out, please provide the following information and submit this form by email to trychop@chop.edu.

Patient First Name _____

Patient Last Name _____

Patient Date of Birth _____

Address (city, state, zip code) _____

Name of Person completing this request _____

Relationship of Person completing form (patient / parent /legal guardian / other)

_____

Contact Information of Person Completing form (phone number and email address)

_____

Reason for opting out _____

I request that CHOP no longer share the health information of me or my child electronically through the HIEs that CHOP participates in. I understand that completing this form will not prevent CHOP from continuing to share information about my care or the care of my child with providers outside of CHOP involved in your care and others as permitted by law. I have read and fully understand this form and all of my questions were answered to my satisfaction. If I am signing as the legal representative of a patient, I confirm that I am legally authorized to act on behalf of the patient. Intending to be legally bound, I agree that entering my signature electronically constitutes my digital signature to this form.

Signature _____

Name _____ Date _____ Time _____

Relationship to Patient _____

Additional information about HIE data sharing

HIEs that CHOP participates with that already have your/your child's information may continue to use and share it even if you complete this form. If you would like to request that they stop doing so, please contact them directly:

- Health Share Exchange: https://www.healthshareexchange.org/patient-options-opt-out-back
- PA Patient and Provider Network (P3N): https://www.dhs.pa.gov/contact/DHS-Offices/Pages/eHealth-HIE%20for%20Citizens.aspx

Questions about completing this form can be emailed to trychop@chop.edu.