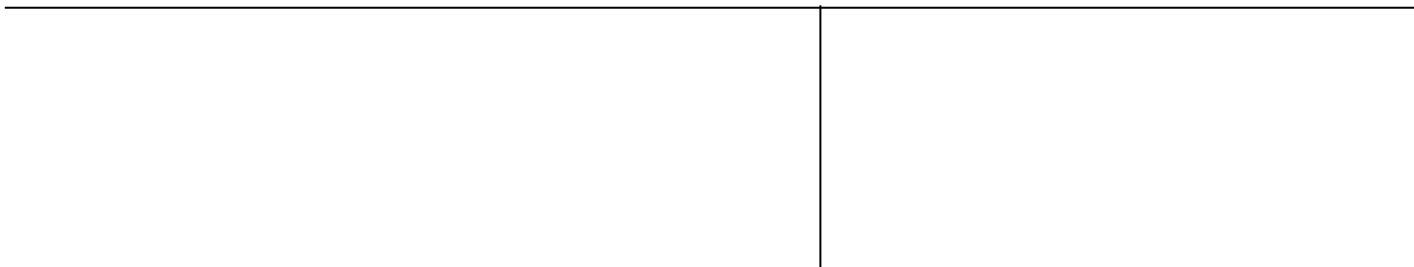


PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

AH MEDICAL RECORD #: \_\_\_\_\_

ADDRESS:





Adventist Health may not share my health information through Adventist Health participating HIEs\*

I request to cancel my previous decision to opt out. By completing and signing this form, I am allowing my health information to be accessible to my health care providers through HIE, as permitted or required by Adventist Health or Federal / State law.

_____		_____	
Print Name		Patient / Legal Representative Signature *	
_____		_____	
Date		AM / PM	Relationship to Patient
_____	_____	_____	_____

*\*By signing as a legal representative, I am certifying that I am legally authorized to act on behalf of the patient*

**Once this form is complete, please return to:**

Virtual Care Coordination Center at: Fax number: 661-637-8890

OR

Email to: [Telehealthcarecenter@ah.org](mailto:Telehealthcarecenter@ah.org)

If you believe your privacy rights have been violated, you may file a complaint with Adventist Health or with the Secretary of the Department of Health and Human Services, Office of Civil Rights. To file a complaint with Adventist Health, contact the Compliance Hotline: (888) 366-3833. You may also submit your complaint in writing and deliver to: Adventist Health Compliance Department, 2100 Douglas Blvd., Roseville, CA 95661.

Adventist Health

REQUEST FOR HEALTH INFORMATION  
EXCHANGE PATIENT OPT-OUT

[ Patient Label ]