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	Time 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

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.