TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER
EL PASO

Health Information Exchange
OPT-OUT REQUEST FORM

I understand that participation in PHIX and /or data interoperability/Health Information Exchange is voluntary and that if I do not want to participate I can choose to opt-out of having my health information viewable, which will include **not** making my information available in emergency situations. If I opt to not have my information shared, my ability to receive health care **will not** be affected.

Please check all boxes below indicating that you have read and understand each of the following statements.

☐ **I understand that by submitting this Opt-Out Request Form and selecting this choice, my health information WILL NOT be viewable by any healthcare providers through the interoperability/HIE system.**

☐ **I understand that by submitting this OPT-OUT Request Form and selecting this choice my health information WILL NOT be viewable in an emergency.**

☐ **I understand that I am free to revoke this Opt-Out Form at any time by requesting this at the front desk of the clinic.**

☐ **I understand that this request only applies to sharing my health information through the interoperability/HIE system. I recognize that when I see a healthcare provider for treatment that provider may request and receive my medical information from other providers using other methods permitted by law.**

☐ **I understand that opting out will be in effect within a reasonable time frame after receipt of this form by the clinic and interoperability /HIE system. My information, prior to the Opt-Out Form date, will be visible to medical providers through the interoperability/HIE system, no information will be stored in the interoperability/HIE system after the Opt-Out Form is in effect.**

A separate form must be filled out for each family member requesting to opt out. **ALL FIELDS NEED TO BE COMPLETED** for this form to be processed. A principal contact telephone number is required in case here is a need to contact you to ensure accuracy of your demographic information.

Patient Last Name	***First Name***	***Middle Initial***	***(Previous Names/Nicknames)***
Mailing Address	***City***	***State***	***Zip Code***
( ) - ***Principal Contact Telephone Number***			***Date of Birth (mm/dd/yyyy)***

_____ _____
Signature of Patient Date Signed

_____ _____
Signature of Parent/Guardian Date Signed

_____ _____
Parent/Guardian Name (Print Name) Parent/Guardian Contact Telephone

☐ **Parent** ☐ **Guardian** ☐ **Other**_____

Section to be completed by TTUHSC staff:

I witnessed the above named individual signing this document and the individual is personally known to me or provided me with valid picture identification on this day_____ of, 20_____.

TTUHSC Witness

Signature: _____ Phone Number: _____

Print Name:_____ Date Signed: _____