healthcurrent

Opt Out Form

Please complete and return this form to your healthcare provider who will return this form to Health Current.

This is the "Opt Out Form" described in the Notice of Health Information Practices your healthcare provider gave to you. If you opt out, your healthcare providers will not be able to access your health information through Health Current, Arizona's health information exchange (HIE), even in an emergency. If you are filling out this form for another person, the references to "you," "I" and "my" in this form refer to that other person.

If you do **not** want your health information shared through Health Current, fill in your name, date of birth and choose either Option 1 or 2. Sign the Opt Out form and give it to your healthcare provider.

Patient Name:_____ **Date of Birth**: _____

Street Address:_____

City:_____ **State**:_____ **Zip**:_____

☐ **Option 1 – Block All Health Information**: I do not want any of my health information shared through Health Current.

☐ **Option 2 – Block Some Health Information**: I do not want health information that comes from the healthcare provider listed below shared through the HIE. I understand that if this healthcare provider works for an organization (like a hospital or a medical group), all of my information from that hospital or medical group may be blocked.

If you select Option 2, provide the full name, address and phone number of the healthcare provider you wish to block from sharing your health information through the HIE. If you want to block more than one healthcare provider, complete and return this form for each healthcare provider.

Healthcare Provider (First and Last Name)	**Address**	**Phone Number**

Signature of Patient or Patient's Parent/Guardian/Healthcare Decision Maker:_____
Print Name:_____ **Date**:_____
If signed by a person other than the patient, please indicate your authority to sign for the patient (check one):

☐ Spouse ☐ Parent/Guardian ☐ Caregiver with authority to make healthcare decisions

If you are signing on behalf of more than one patient (such as your children), you must fill out a separate form for each patient.

Provider Office Only: This section must be completed before sending via secure fax to Health Current.

Organization/Provider:_____

Print Name:_____ Date:_____

Signature:_____ Phone:_____