REVOCATION OF PRIOR HEALTH INFORMATION EXCHANGE (HIE) OPT-OUT

Name:___________________________________ Date of Birth: __/____/ ____

Street Address: ____

City:_______________________________________ State:________Zip: _____________

Phone:___________________________________ e-mail: _______________________

I hereby acknowledge and agree as follows:

1. I WISH TO REVOKE (change) my prior decision to Opt-Out of the Inspira NJSHINE HIE, and now I **specifically AUTHORIZE** my information maintained in the Inspira NJSHINE HIE to be electronically available to my providers;
2. I UNDERSTAND that by making this selection, now ALL of my authorized providers who participate in the <Named> HIE or are connected to the Inspira NJSHINE HIE will have access to my health information maintained in the Inspira NJSHINE HIE.
3. I UNDERSTAND that by making this selection, my health information may be accessible by other Health Information Exchange(s) with whom the Inspira NJSHINE HIE participate.
4. I UNDERSTAND that this Revocation can only be changed if I specifically submit a new HIE Opt-Out form;
5. I have had an opportunity to have all my questions regarding this “Revocation of Prior Opt-Out” and others answered; and
6. This request can take **2 business days upon receipt t**o take effect.

Signature:__________________________________ Date: __________________

Legal Representative Name:____________________________ Relationship to Patient: __________

Date Received by Inspira:_____________ Inspira Signature: _______________________

Completed and signed Revocation of Prior Inspira Health Information Exchange Opt-Out form can be returned to the Inspira Health Information Management Department; faxed to 856-575-5022 or mailed to:

Inspira NJSHINE HIE
Inspira Health
1505 West Sherman Ave
Vineland NJ 08306

Effective July 2021