

ONEPARTNER HEALTH INFORMATION EXCHANGE

PATIENT PARTICIPATION CHANGE FORM

See Instructions On Reverse

This form expresses a Patient's decision to Opt-In or Opt-Out at the OnePartner Network Level

Patient:

Name: _____

Address: _____

DOB: _____

City: _____

Last 4 digits of SSN: _____

State: _____

Change Being Requested

Zip: _____

FROM: Opt-In Opt-Out

Circle Your Choices

E-mail: _____

TO: Opt-In Opt-Out

Phone: _____

Patient Signature:

Print: _____

Date: _____

Please allow three (3) business days for the requested change to take effect.

*****GO CKN THIS FORM TO:

onepartnerconsentsupport@onepartner.zendesk.com

Please allow three (3) business days for your changes to take effect.

INSTRUCTIONS

Instructions for the Patient:

“Opt-In” means that you, the patient, are participating in the OnePartner Health Information Exchange at the “Network Level.” Your decision to Opt-In means your records from ALL health care providers with whom you have a treatment relationship are available to your other treating providers in the Network.

“Opt-Out” means that you, the patient, are NOT participating in the OnePartner Health Information Exchange at the “Network Level.” Your decision to Opt-Out means your records from ALL health care providers with whom you have a treatment relationship will NOT be available to your other treating providers in the Network.

If you choose to opt out, other health care providers will not be able to view your health information through the OnePartner Network. Your records may not be electronically available during a personal or local emergency.

Your decision using this form will affect your availability of your records from ALL providers participating in the OnePartner Health Information Exchange. You do NOT need to fill this form out at each health care provider. One time is sufficient.