SHARE
Version Number: 1.0

SHARE
State Health Alliance FOR Records Exchange

Health Information Exchange Patient Opt-Out Form

This form is for patients who DO NOT wish to participate in the Arkansas State Health Alliance for Records Exchange (SHARE) or who wish to revoke an earlier decision.

This form allows you to limit electronic access of your health information. The Arkansas State Health Alliance for Records Exchange (SHARE) is an electronic health information exchange that your treating providers use to share health care information about you in order to provide higher quality and better coordinated care. Your health information will be available electronically to your treating providers unless you decide to opt-out and not have your information shared electronically.

If you opt-out, your treating providers will not be able to access your health information by making an electronic inquiry through SHARE except in the case of a medical emergency. You have the option to change your mind and terminate your opt out decision. You may request a copy of this form. If you sign as a legal representative, all references in this form refer to the patient.

INSTRUCTIONS: If you do not wish to make your health information available through SHARE, check only one box and provide all requested information below. Please print, sign and date the form.

☐ **Request to Opt-Out.** I choose to opt-out. I do not want my authorized health care providers to access my health information by making an electronic inquiry through SHARE.

OR

☐ **Request to terminate my previous decision to Opt-Out.** I want to reverse my previous decision to opt-out. By completing and signing this form, I am allowing my health information to be accessible to my authorized health care providers through SHARE, unless restricted by applicable law.

Patient Name: ______________________________ **Gender**: Male / Female
Last, First, Middle Initial (Circle One)

Date of Birth: ____/_____/________ **Previous or Other Last Name**: ______________________________

Street Address: ______________________________ **Apt. #**: ____________

City: ______________________________ **State**: __________ **ZIP**: __________

Legal Representative: ______________________________
(If Applicable)

Relationship to Patient: ______________________________

Signature: ______________________________ **Date**: ____/____/______

The portion below must be completed by Health Care Provider. *Please ensure your patient has completed all information above.*

Name of Health Care Provider: ______________________________

Phone: ____________________ **Fax:** ____________________

Address: ______________________________

Date form entered into electronic system by SHARE: ______/______/__________

OHIT
Arkansas Office of Health Information Technology