Facility Location: _____ **Phone:** _____

RioOne OPT-OUT REQUEST FORM

I understand that participation in a Health Information Exchange (HIE) 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 initial all boxes below indicating that you have read and understand each of the following statements.

☐ I understand that by submitting this *RioOne HIE Opt-Out Request Form* and selecting this choice, my health information will not be viewable in the RioOne HIE system or viewable by any health care providers through the RioOne HIE system.

☐ I understand that by submitting this *RioOne HIE 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 and can do so by completing a *RioOne Health Information Exchange (HIE) Revocation of Opt-Out Form* that can be obtained from RioOne's website at **www. rioonehie.com or from my health care provider**.

☐ I understand that this request only applies to sharing my health information through the RioOne HIE system. I recognize that when I see a health care provider for treatment that provider may request and receive my medical information from other providers using other methods permitted by law, such as fax or mail.

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 contact phone number is required in case RioOne needs to contact you to ensure accuracy of your demographic information.*

Patient Last Name	First Name	Middle Init	(Previous Names/nicknames)
Mailing Address	City	State	Zip Code
( ) Contact Phone Number	Social Security # (Last four digits)		Date of Birth (mm/dd/yyyy)

Signature of Patient _____ Date Signed _____

Signature of Parent/Guardian _____ Date Signed _____
If patient under 18 years, signature of patient guardian

☐ Parent ☐ Guardian ☐ Other: _____

Parent/Guardian Name _____

Section to be completed by a Notary Public or Health Care provider (or office 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_____.

Notary or Provider Signature: _____ Phone #: _____

Must be original signature in Blue or Black Ink

Print Name: _____ Date Signed: _____

PRACTICE ADMINISTRATOR: Please send the completed form via RioOneReferral to "RioOne consent forms-sent here" (searchable in Location tab) or fax to 956-362-3177