MU Health Care

Tiger Institute Health Alliance: Health Information Exchange
OPT-OUT

Patient Name (First Middle Last):
_____

Date of Birth (mm/dd/yyyy): __/___/_____ Telephone Number: _____

Address: _____City:_____State:_____Zip:_____

I hereby acknowledge, understand and agree as follows:

I WISH to **Opt–Out of the Tiger Institute Health Alliance: Health Information Exchange (TIHA HIE).** I understand that by making this selection, **NONE** of my health care providers will be able to access my health information maintained anywhere on the HIE, even in cases of a medical emergency;

- My providers who originally generated information about me **will continue to have access** to my information, but only in the medical record that *they* created for me, or by obtaining it via previously established methods;
- This **HIE Opt-Out** will NOT allow TIHA to make my health information available to other connected HIEs with whom TIHA participates, even in cases of a medical emergency;
- This **HIE Opt-Out** does NOT cover or effect my opting-out of any other HIE(s). I UNDERSTAND that if I wish to opt-out of another HIE, I am responsible for approaching my provider participating in such other HIE(s) about how I can do that;
- Once this **HIE Opt-Out** goes into effect, I can change my mind **only by** submitting a **Cancellation of Prior OPT-OUT** form;
- I have had an opportunity to have all of my questions about this "Tiger Institute Health Alliance: Health Information Exchange OPT-OUT" and any others answered; and
- My **Opt-Out** will become effective when the participating HIE provider has notified TIHA to process this revocation, which may take up to 5 business days; and

Any information that is disclosed / accessed before I submit this HIE Opt-Out cannot be taken back and will remain in the TIHA HIE and my provider who may have accessed such information before this Opt-Out went into effect.
My **HIE Opt-Out** selection will remain in effect unless I change it in writing.

X_____ _____
Signature of Patient or Patient's Legal Representative Date Signed (mm/dd/yyyy)

X_____ _____
Print Name of Legal Representative (if applicable) (Relationship to patient)

Completed and signed TIHA HIE Opt-Out forms can be returned to MU Health Care Clinics, Hospitals Registration/Reception Desk; FAX# 573-882-3209 or mailed/ hand delivered to:
Health Information Services
University Hospital
One Hospital Drive DC 042.00
Columbia, Missouri 65212