Name MRN DOB Patient Identification	VCU Health VCU Medical Center Richmond, Virginia **Health Information Exchange (HIE) Opt Out For Adult Patient or Child Age 0 to 18**

VCU Health participates in the MedVirginia Health Information Exchanges (HIE), a secure internet based health record exchange which allows patient information to be shared electronically with physicians and other providers/facilities involved in your health care. You may "opt-out" of the HIE by completing and submitting this HIE Opt-Out form by mail, email, or fax to:

VCU Health Department of Health Information Management
Mail: P.O. BOX 980679 Richmond, VA 23298-0679
Email: HIM@VCUHEALTH.ORG
Fax: (804) 828-5059
Phone: (804) 828-5501

Please Note: Opting out of participating in the HIE means that your records will be shared by other means, such as fax or mail.

Adult Patient or Child Age 0 to 18: NOTE: Please print legibly		
Patient Name: (include middle name or initial)	Birthdate:	Optional: Last 4 digits #s of SSN: _____ (for child w/no SSN, use parent's SSN)
Patient's Home Address:		
◯ **Opt Out - I/Parent or Legal Guardian choose to Opt Out of the Health Information Exchange (HIE)**		
By signing below I confirm that I have read and understand that opting out does not restrict the release of patient information by means other than the HIE.		
Signature of Adult Patient or Parent/Legal Guardian of Child 0 to 18: (Required)	Date/Time Signed:	
If signature other than patient's, please indicate relationship: ___ Parent ___ Legal Guardian** ___ Other (specify)_____ ** This request must be accompanied by a copy of legal paperwork verifying the individual's status as Legal Guardian.		
◯ **Revoke Opt Out – I/Parent or Legal Guardian choose to Revoke my previous decision to Opt Out of the Health Information Exchange (HIE)**		
By signing below I confirm that I have read and understand that revoking the Opt Out will allow the release of patient information to resume via the HIE.		
Signature of Adult Patient or Parent/Legal Guardian of Child 0 to 18: (Required)	Date/Time Signed:	
If signature other than patient's, please indicate relationship: ___ Parent ___ Legal Guardian** ___ Other (specify)_____ ** This request must be accompanied by a copy of legal paperwork verifying the individual's status as Legal Guardian.		