

## Health Information Exchange (HIE) Patient Opt-Out Form

**Patient Information****Patient Name** \_\_\_\_\_**Date of Birth** \_\_\_\_\_**Address** \_\_\_\_\_

Please confirm the date of the original authorization \_\_\_\_\_

By signing this form, I am exercising my right to OPT-OUT of the Health Information Exchange (HIE). I understand that:

**1. Action Requested**

Please select the change you wish to make to your existing HIPAA Release Authorization

- Full Revocation: Cancel all future disclosures of my health information to the recipient(s) named on the original form.
- Partial Modification: Change specific details of my existing authorization

**2. Specific Modifications (If Applicable)**I wish to modify my previous authorization as follows (e.g., change recipient, limit date range, or exclude specific conditions):  
\_\_\_\_\_**By signing this form, I understand and agree to the following:**

- This request is effective upon receipt by the CloseKnit Privacy Officer.
- I understand that Opting-out cannot "undo" any disclosures already made in reliance on my original authorization.
- While we halt disclosures immediately upon receipt, please allow 5–7 business days for all internal systems to reflect these changes.
- This request does not apply to disclosures required by law or those permitted without authorization (such as for treatment, payment, or healthcare operations).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Parent or Legal Guardian signature required if patient is a minor)