

**REVOCAION OF CONSENT TO OPT-IN TO
THE HEALTH INFORMATION EXCHANGE (HIE)**

The Health Information Exchange (HIE) allows your doctors, hospitals, and other healthcare providers to share your health information electronically.

If you have previously consented to opt-in to the HIE, Cox Health hospitals and providers share your health information for treatment purposes with your other healthcare providers outside of Cox Health.

Name: _____
Date of Birth: _____
Address: _____
City/State/Zip: _____
Phone: _____

This revocation form will cancel any prior written consent to share your health information outside of Cox Health. Any information shared prior to the receipt of this revocation form will not be affected. Providers are not required to remove any of my medical records that were shared with them before the date of this revocation.

By signing this form, you acknowledge that you understand the following statements:

- This form only applies to medical records shared by Cox Health with outside providers. I am signing this form because I do not want my Cox Health medical records shared with outside providers.
- I understand that signing this form does not impact medical records outside Cox Health.
- I may choose to opt back in to sharing my Cox Health medical records at any time by signing a "HIE Notification" form.
- I am aware that other providers who originally recorded information about me may continue to have access to this information through means other than the HIE.
- Providers outside of Cox Health will no longer have access to information about my health in my Cox Health records. This may impact these providers' ability to see a complete picture of my health, which could limit their ability to make decisions about my care.

/ / DATE	: TIME	_____ SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN/RELATIONSHIP	_____ PRINTED NAME
/ / DATE	: TIME	_____ WITNESS SIGNATURE	_____ PRINTED NAME

DO NOT WRITE BELOW THIS LINE