Camden Coalition
HEALTH INFORMATION EXCHANGE

CANCELLATION OF PRIOR CAMDEN HIE OPT-OUT FORM

Name_____ Date of Birth ____/____/_____

Street Address: _____

City: _____ State:_____ Zip:_____

Phone:_____ Email:_____

I hereby acknowledge and agree as follows:

1. I WISH TO cancel my prior decision to OPT-Out of the Camden HIE, and now I specifically AUTHORIZE my information maintained in the Camden HIE to be electronically available to my providers;

2. I UNDERSTAND that by making this selection, now ALL of my authorized providers who participate in the Camden HIE or are connected to the Camden HIE will have access to my health information maintained in the Camden HIE;

3. I UNDERSTAND that by making this selection, my health information may be accessible by other HIEs with whom the Camden HIE participate.

4. I UNDERSTAND that this cancellation can only be changed if I specifically submit a new Camden HIE Opt-Out form;

5. I have had an opportunity to have all my questions regarding this "Cancellation of Prior Camden HIE Opt Out"' and others answered; and

6. This request can take 2-3 business days to take effect.

Signature: _____ Date:_____

If Legal Rep, state Authority: _____

This completed and signed Camden HIE Opt-Out form can be faxed to 856-365-9520 or mailed to:

Camden HIE Administrator
c/o Camden Coalition of Healthcare providers
800 Cooper Street 7th Floor
Camden NJ, 08102