

Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

STANFORD HEALTH CARE
STANFORD MEDICINE PARTNERS
STANFORD HEALTH CARE TRI-VALLEY
STANFORD MEDICAL CHILDREN'S HEALTH
PACKARD CHILDREN'S HEALTH ALLIANCECONSENT • REQUEST TO CANCEL HEALTH
INFORMATION EXCHANGE EXEMPTION**Patient Request to Cancel Exemption from Participation (“Opt Out”) in Electronic Health Information Exchange (HIE)**

This form is for patients who receive health care from these Stanford Medicine providers:

- Stanford Health Care
- Stanford Medicine Partners
- Stanford Health Care Tri-Valley
- Stanford Medicine Children's Health
- Packard Children's Health Alliance

Reverse my Prior Opt-Out: I previously chose to opt-out of Care Everywhere and the electronic sharing of my health information with external healthcare organizations and providers. I am now choosing to participate (opt-in) and to allow my information to be shared via Care Everywhere to external healthcare organizations/providers. By checking this box and signing this form, I am reversing my prior request to exclude my health information from Care Everywhere.

Name of patient (please print):

Name of legal representative signing this form, if applicable (please print):

Address of patient or legal representative signing this form (please print):

Phone number of patient or legal representative signing this form:

If you are not the patient and you are signing this form, describe your authority to sign on behalf of the patient and provide supporting legal documentation:

*Legal Representative's Name (print) and Relationship***Signature of patient or legal representative:** _____ **Date:** _____