PRINT SAVE AS EMAIL RESET

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 MEDICINE CHILDREN'S HEALTH
PACKARD CHILDREN'S HEALTH ALLIANCE

CONSENT PATIENT REQUEST FOR EXEMPTION

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
- Lucile Salter Packard Children's Hospital at Stanford
- Packard Children's Health Alliance

Stanford Medicine participates in a secure electronic sharing module, Care Everywhere, a health information exchange (HIE) which is available to health care providers who utilize the Epic electronic medical record system. Care Everywhere helps us safely share information with other members of your care team, even if they are not Stanford Medicine healthcare providers. This allows non-Stanford Medicine providers to request and receive health information needed to treat you. If you get care from non-Stanford providers or in other states, your health information is shared with those hospitals, clinics, doctors, and other healthcare providers.

Most of your health information is automatically included in Care Everywhere unless you request it be excluded. There may be certain records that are not included in Care Everywhere due to additional restriction requirements.

More information about electronic HIEs is available here: https://stanfordhealthcare.org/for-patients-visitors/medical-records.html

This form must be filled out if you want to "opt out" (not participate) in [our secure electronic HIE that includes] Care Everywhere. You may change this decision at any time.

_____ **Opt-out:** By checking this box and signing this form, I request that my medical information be excluded from Care Everywhere.

- I understand that by opting out of Care Everywhere, healthcare providers outside of Stanford Medicine will not be able to obtain my health information electronically through Care Everywhere, including in an emergency, except to the extent action has already been taken to release information prior to receipt of this opt-out request.
- I understand that my information may still be shared through other HIEs for reporting purposes, as required by law, and that external healthcare providers treating me can still obtain this treatment information by other means, such as placing a request with the applicable Health Information Management Services department.
- I understand that Stanford Medicine cannot block access to my medical record by health care providers who utilize our electronic medical record.
- I understand that this opt-out request only applies to information created by Stanford Medicine; if I would like to opt-out of Care Everywhere at another external medical facility or provider that utilizes the Epic medical record, I must contact that facility/provider.
- I understand that my decision not to participate in Care Everywhere is in effect until I change my choice by completing this form again and checking the box to reverse my prior opt-out.
- I understand that my decision to not participate in the secure electronic HIE, may take up to two (2) business days to take effect.

CONSENT PATIENT REQUEST FOR EXEMPTION

If you have questions about this form or the sharing of your health information, please contact:

- Stanford Health Care, Health Information Management Services at 650-400-9817; or
- Stanford Medicine Children's Health, Health Information Management Services at 650- 497-9322

Please note, once you've opted out, it will result in an opt out at all of our affiliated organizations.

Please print the patient's name (first, middle, last): _____

Address: _____

Medical record number (if known): _____ Date of birth: _____

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

_____

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

_____

Phone number of patient or legal representative: _____

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:

_____

Signature of patient or legal representative: _____ Date: _____

Please return this form via mail, to the Stanford Health Care facility listed below:

Stanford Health Care
Health Information Mgmt., MC 6330
300 Pasteur Drive
Stanford, CA 94305
Telephone: 650-723-5721
Fax: 650-725-9821