Florida Health Information Exchange (HIE) Opt-Out Form

Please complete this form if you do not want to share your clinical data in the Florida Health Information Exchange.

What is a Health Information Exchange?

A Health Information Exchange (HIE) is a secure electronic way for health care providers and organizations to share clinical information about their patients. In Florida, we have the Florida Health Information Exchange, often referred to as the Florida HIE or the HIE.

Why do health care providers have to share clinical information?

When you need to receive care, it is critical that your health care provider has the most recent information about your health. Your provider can search the Florida HIE for your health information to reference while providing your care. There are many reasons providers share patients' clinical information. For example, it helps ensure against repeating tests or receiving medications that negatively interact with each other. Providers may also share your data to ensure everyone is on the same page when providing you with health care.

What if I don't want to share my clinical information through the Florida HIE?

You may follow the directions below to opt out of sharing clinical information through the Florida HIE. This does not remove your data from the electronic health record systems that may be used by your providers, it merely prevents your data from being shared with the Florida HIE.

What happens once I complete my opt-out form?

Your health information will be deleted from the Florida HIE within 5 business days. Once your data is deleted, your provider will not be able to search in the Florida HIE for your health information. However, some providers may use other electronic methods to send information about their patients to each other directly. This is the same as when providers share information by fax or mail.

If a provider searched the Florida HIE for your information and put that information into their medical records before you completed your opt-out form, that information will remain in that provider's medical records.

What if I change my mind and want to share my clinical information?

We are happy to help. Please call us at **(866) 987-5514** or reach out via **info@flhie.org** so we can make that change for you. Unfortunately, we cannot retrieve the information that was deleted when you opted out, so your historical clinical information will not be in the Florida HIE and the only data available will be data collected after you have reversed your opt-out.

Are there exceptions to my choice to opt-out?

Yes. Public health reporting, such as the reporting of infectious diseases to public health officials, will still occur through the Florida HIE after you decide to opt out. Also, Controlled Substances information, as part of the Prescription Drug Monitoring Program, will continue to be available through the Florida HIE to licensed providers.

Do I have to fill this form out every year?

No, you only need to fill it out once for yourself. We will keep this information and your decision in place until you decide to opt back in.

If I live in another state and only get care in Florida OR I only live in Florida part-time, will my data be removed from other states as well?

No, the Florida HIE opt out form only applies to care delivered in Florida. If you would like your data removed from another state's HIE you will need to reach out to that HIE directly.

If you wish to reverse your decision, you may opt back in at any time by calling **866-987-5514**.

All information below is necessary in order to process the request, unless otherwise noted.

First Name: _____

Middle Name (optional): _____

Last Name: _____

Email: _____

Primary Phone: _____

Secondary Phone: _____

Date of Birth: _____

Sex (please circle): _____Male_____Female_____Other_____Rather Not Share____

Address: _____

Address 2: _____ **City:**_____

State: _____ **Zip:**_____

Please check the applicable boxes below:

☐ **Opt-out of all sharing –** Opt-out of all sharing of your through health information exchange, including research and patient portals. Your data will not be available in an emergency or for any of your healthcare providers.

Authorized Representative (if applicable)

If this form is submitted by someone other than the person named above, the person submitting this form hereby certified that he/she/ is acting as:

☐ Parent ☐ Legal Guardian ☐ Other

Confirmation Notification Preference

I would like to be notified of my participation choice in the following way (choose one):

☐ Email ☐ Phone ☐ Letter

☐ Text Message ☐ No Notification

Signature and Acknowledgment

By signing below, I acknowledge that I am choosing to opt out of sharing my clinical information through the Florida Health Information Exchange and understand the implications of this decision as described above.

If you are completing this form on behalf of someone else, please sign and print your own name below, as well as provide your phone and email.

Signature:_____

Printed Name:_____

Date: _____

Email: _____

Primary Phone: _____