**CalMHSA Connex Health Information Exchange Patient Opt-out Form**

## □**Opt-Out**

## My information may not be accessed through the CALMHSA CONNEX HIE.

*\*Please note that opting out of the CALMHSA CONNEX HIE will only prevent your data from being accessed via the CALMHSA CONNEX HIE system.* ***Opting out of the CALMHSA CONNEX HIE does not prevent your caregivers from sharing your information.*** *If you wish to completely halt the sharing of your information electronically, you must reach out to each organization/provider(s) and request to do so.*

□**Cancel Opt-Out**

## I request you to cancel my previous decision to opt-out. By completing and signing this forum, I am allowing my health information to be accessible to my health care providers through the CALMHSA CONNEX HIE, as permitted or required by Federal or State law.

*All fields must be filled out to process your opt-out request.*

First Name, Middle Initial, Last Name

*\*If you are a legal representative/authorized individual, please add your name after the patient’s name with your relation to the patient.*

Street Address

City, State Zip Code

Birth Date (MM/DD/YY) Gender (M, F, Other) Last 4 Digits of Social Security Number

Client/Patient Signature or Legal Representative\* Date (MM/DD/YY)

*\*By signing as a legal representative, I am certifying that I am legally authorized to act on behalf of the patient.* ***Identification verification will be required for both patient and/or legal representative/authorized individual to complete the request.***