Chesapeake Regional Healthcare HIE Patient Opt-Out Form

Please fill out and mail this form to:

Privacy Officer
Health Information Department
Chesapeake Regional Medical Center
736 Battlefield Blvd North
Chesapeake, VA 23320

Select one option below:

___ **Partial Opt-Out** – HIE may not share health information maintained by the provider or health care organization(s) below. I understand that all health information maintained by the providers below will not be part of my patient health record in the HIE. In cases of medical emergency, my doctor may request to view my health record to diagnoses or treat my emergency.

___ **Full Opt-Out** – HIE may not share any of my health information.

___ **Rescind Opt-Out**

I request to terminate my previous decision to opt-out. By completing and signing this form, I am allowing my health information to be accessible to my health care providers through the HIE.

All fields must be filled out in order for HIE to process my opt-out or rescind opt-out request.

First Name | Last Name | Middle Initial

Address

City | State | Zip Code

Date of Birth | Gender | Last 4 digits Social Security Number

Patient Signature or Legal Representative | Date (Month, Day, Year)