ICARE SYSTEM OPT-OUT FORM

I understand that if I have already signed a consent or authorization form allowing my information to be shared electronically through ICare I do not need to sign this Opt-Out form and that my health information will continue to be shared through ICare.

The Connxus Health Information Exchange, "the ICare System", has been explained to me. I understand that my participation in the ICare System is voluntary and that if I do not want to have my Protected Health Information("PHI") reviewable and shared electronically through the ICare System I can sign this Opt-Out form. If I Opt-Out my healthcare providers will not be able to quickly access my PHI electronically through the ICare System, While I will not be denied care, I understand that it may take longer for me to get medical care as my health care provider will have to obtain information about my medical condition by contacting my other providers and discussing my condition or obtaining records from each provider.

Please read the following and sign below:

1. I wish to Opt-Out of the ICare System.

2. By Opting-Out of the ICare system:

NONE of my health care providers, plans or payors will be able to electronically access my health information through the ICare System, **except**:

a. in a Medical Emergency; or
b. if I revoke my Opt-Out decision.

3. My Opt-Out selection will remain in effect unless I submit a Connxus Revocation of Opt-Out Form directly to Connxus;

4. I have had an opportunity to ask questions about this "ICare System Opt-Out Form".

5. Any information that is disclosed before I submit this ICare System Opt-Out Form cannot be taken back and will remain with my healthcare provider who may have accessed such information before this ICare System Opt-Out Form went into effect; and

6. My request to Opt-Out can take up to three **(3) business days** upon receipt to take effect.

ICARE SYSTEM OPT-OUT FORM

A separate ICare System Opt-Out Form must be submitted for each family member requesting to Opt- Out of the ICare System.

_____
Patient Name

_____
Mailing Address City State Zip Code

(___)_____-_____
Contact Phone Number Last 4 digits of Social Security # Date of Birth

_____
Signature of Patient Date Signed

_____
Signature of Parent/Legally Authorized Representative [ ] Parent [ ] Guardian [ ] Other

Provider Location: _____

Completed and signed ICare System Opt-Out Form can be returned to Connxus in the following ways:

By Mail – Connxus, 1401 Lavaca St. PMB 40115, Austin, TX 78701.
By Email - scan and send to info@connxus.org