Opt-*OUT* Request Form

I, _____, prefer that my healthcare records
Your Name
from Decatur Memorial Hospital Health Systems NOT be shared through allcharts™.

NOTE: This Opt-Out Request will prevent your records from Decatur Memorial Hospital Health Systems from being shared through allcharts™. If you have records at other healthcare organizations which you wish to Opt-Out, you will want to complete an Opt-Out Request Form at those offices. Only a designee from that organization can mark your records as opted out.

PLEASE INITIAL

_____ I understand that by submitting this Opt-Out Request Form, my health information from Decatur Memorial Hospital Health Systems will NOT be viewable by clinicians at other organizations who may provide me with treatment. (This Opt-Out will be processed within 5 business days of receipt of the completed form.)

_____ I understand this opt-out ONLY applies to sharing my health information through allcharts™. When I see a healthcare provider for treatment, the provider may request and receive my medical information from other organizations using other non-electronic methods, such as fax, mail or phone.

(A separate form must be filled out for each family member requesting to opt out. All fields are required for form to be processed. A contact phone number is required in case CIHIE needs to contact you to ensure accuracy of demographic information.)

Patient First Name:	Patient Middle Name:	Patient Last Name:
Date of Birth (mm/dd/yyyy):		Contact Phone Number:
Mailing Address:		City, State, Zip Code:
Name of Primary Physician (if known):		

_____ _____
Signature of Patient (or authorized representative) Date Signed

_____
Name of Person Signing Form (please print legibly)

_____
If signed by authorized representative, what is your relationship to Patient?

8105

Mail Completed Form to:
Decatur Memorial Hospital
2300 N. Edward Street
Decatur, IL 62526
Attention: Medical Records - CIHIE