healthcurrent

Opt Out Form

If you do not want your health information shared through Health Current, please complete and return this form to your healthcare provider. Your healthcare provider will return the form to Health Current.

This is the "Opt Out Form" described in the Health Current Notice of Health Information Practices. If you opt out, your healthcare providers will not be able to access your health information through Health Current, Arizona's health information exchange (HIE)—even in an emergency. If you are filling out this form for another person, the references to "you," "I" and "my" in this form refer to that other person.

If you do **not** want your health information shared through Health Current, fill in your name and date of birth below. Then, check the box that says, "Opt Out." Finally, sign the form and give it to your healthcare provider.

Patient Name:_____ **Date of Birth**: _____

Street Address:_____

City:_____ **State**:_____ **Zip**:_____

☐ **Opt Out**: I do not want any of my health information shared through Health Current.

Signature of Patient or Patient's Parent/Guardian/Healthcare Decision Maker:_____

Print Name:_____ **Date:**_____

If signed by a person other than the patient, please indicate your authority to sign for the patient (check one):

☐ Spouse ☐ Parent/Guardian ☐ Caregiver with authority to make healthcare decisions

If you are signing on behalf of more than one patient (such as your children), you must fill out a separate form for each patient.

Provider Office Only: This section must be completed before sending via secure fax to Health Current.

Organization/Provider: _____

Print Name:_____ Date:_____

Signature:_____ Phone:_____