ALMA

Health Information Exchange Patient Opt-Out Form

This form is to be used by patients who do not wish to participate in Amarillo Legacy Medical ACO Health Information Exchange (HIE).

A Health Information Exchange, or HIE, is a way of sharing your health information among participating doctors' offices, hospitals, labs, radiology centers, and other health care providers through secure, electronic means. The purpose is so that each of your participating caregivers can have the benefit of the most recent information available from your other participating caregivers when taking care of you. When you opt out of participation in the HIE, doctors and nurses will not be able to search for your health information through the HIE to use while treating you.

For more information about opting out or rejoining the ALMA HIE,

please visit www.amarilloaco.com, or email hie@amarilloaco.com .

You have several options for opting out of the ALMA Health Information Exchange. Please select one below.

1. Provide this completed form to your ALMA provider's office.
2. Fax your completed form to 806-677-2024
3. Mail your completed form to ALMA-HIE, 1215 S Coulter St, Ste 400, Amarillo, TX 79106

Information for Patient Opting Out

First Name: ______________________________
Middle Name: ______________________________
Last Name: ______________________________
Address Line 1: ______________________________
Address Line 2: ______________________________
City : ______________________________
State: ______________________________
Zip Code: ______________________________
Primary Phone Number: ______________________________
Secondary Phone Number: ______________________________
Email: ______________________________
Date of Birth: ______________________________
Sex (M/F): ______________________________

Reason for Opting Out (optional): ______________________________

If this form is signed by someone other than the person named above, the person signing the form hereby certifies that he/she is acting as: (CHECK ONE) ____ Parent ____ Legal Guardian ____ Other (Specify Relationship) ______________________ for the person named above.

*Contact Information for Individual Completing This Form If Other Than Patient (Please Print Clearly)**

Printed Name ______________________________ Phone Number: ______________________________

*Patient Information (Please Print Clearly)**

Printed Name ______________________________

Signature______________________________ Date: ______________________________