CRISP

Connecting Physicians With Technology to Improve Patient Care in Maryland

Health Information Exchange Patient Opt-Out Form

This form is to be used by patients who do not wish to participate in Maryland's statewide 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. Your physician or other treating providers will still be able to select the HIE as a way to receive your lab results, radiology reports, and other data sent directly to them that they may have previously received by fax, mail, or other electronic communications. Public health reporting, in accordance with law such as the reporting of infectious diseases to public health officials, will also occur through the HIE after you decide to opt out.

This opt-out form only needs to be completed once to opt out of the HIE; it is not necessary to complete for each provider. If you do not live in Maryland but still receive care in Maryland, you should complete this form to opt out. If you wish to reverse your decision you may opt back in at any time by calling CRISP at 1.877.95.CRISP.

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

1. Visit the CRISP Web site at http://www.crisphealth.org
2. Call 1.877.95.CRISP (27477)
3. Fax your completed form to 443.817.9587
4. Mail your completed form to CRISP, 7160 Columbia Gateway Drive, Suite 230, Columbia, MD 21046

Information for Patient Opting Out (Please PRINT Clearly)

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)*

I would like to be notified of my participation choice in the following way (contact information must be included on form): ☐ Email ☐ Phone Call ☐ Letter ☐ Text ☐ No Notification

* Required

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 _____