Name MRN DOB Patient Identification	**CENTRA** **All Facilities** **Health Information Exchange (HIE) Opt Out** **For Adult Patient Or Child Under 18**

Centra participates in the Health Information Exchanges (HIE), a secure internet based health record exchange which allows patient information to be shared electronically with physicians and other providers / facilities involved in your health care. You may "opt-out" of the HIE by completing and submitting this HIE Opt-Out form by mail, email, or fax to:

Centra
ATTN: Lynchburg General Hospital - Patient Access / Registration
1901 Tate Springs Road
Lynchburg, Virginia 24501
Fax: 434-200-5035
Phone: 434-200-3021

Please Note: Opting out of participating in the HIE means that your records will be shared by other means, such as fax or mail. Please allow 7-10 business days for processing once form received.

Adult Patient or Child under 18 NOTE: Please print legibly		
Patient Name: (include middle name or initial)	Birthdate:	Optional: Last 4 digits #s of SSN:___________________ (for child w/no SSN, use parent's SSN)
Patient's Home Address:		
( ) **Opt Out - I / Parent or Legal Guardian choose to Opt Out of the Health Information Exchange (HIE)**		
By signing below I confirm that I have read and understand that opting out does not restrict the release of patient information by means other than the HIE.		
Signature of Adult Patient or Parent / Legal Guardian of Child under 18: (Required)	Date / Time Signed:	
If signature other than patient's, please indicate relationship: ____ Parent ____ Legal Guardian** ____ Other (specify) ____ **This request must be accompanied by a copy of legal paperwork verifying the individual's status as Legal Guardian.		
( ) **Revoke Opt Out - I / Parent or Legal Guardian choose to Revoke my previous decision to Opt Out of the Health Information Exchange (HIE)**		
By signing below I confirm that I have read and understand revoking the Opt Out will allow the release of patient information to resume via the HIE.		
Signature of Adult Patient or Parent / Legal Guardian of Child under 18: (Required)	Date / Time Signed:	
If signature other than patient's, please indicate relationship: ____ Parent ____ Legal Guardian** ____ Other (specify) ____ **This request must be accompanied by a copy of legal paperwork verifying the individual's status as Legal Guardian.		

Patient Label

Original Copy for Medical Record