# OPT OUT/REVOKE OPT OUT

STATE OF NORTH DAKOTA
NORTH DAKOTA HEALTH INFORMATION NETWORK
SFN 60146 (5-2013)

The North Dakota Health Information Network (NDHIN) is a secure computer system that allows your health caregivers to view your health information such as medicines, allergies, test results, health problems, and treatments to help them make better decisions about your care. Information is encrypted and sent over a secure network.

Only Participants and Authorized Users may access your information. Your provider and the NDHIN maintain records of who accessed your information.

Participation is voluntary. You may choose to opt out of participation in the NDHIN or change a prior election by completing and signing this form and returning it to your health care provider or by sending it to the following address. You may also complete the form at www.ndhin.org/consumers/opt-out-participation.

North Dakota Health Information Network
600 E. Boulevard Ave, Dept. 112
Bismarck, ND 58505-0100

- It may take five (5) business days to process this request.

- Your decision to opt out of participation in the NDHIN will not affect the sharing of your health information between your health care providers and health insurers or with health care providers by other methods, such as FAX, mail, etc.

- Participating in the NDHIN is not a condition to receiving care. However, if you opt out of participation in the NDHIN, your health information cannot be searched for through the NDHIN by a health care provider except as required by law or as authorized by you in an emergency. This may affect the information available to your health care provider that could affect treatment options and health care decisions.
  - Your health care provider may not have the most current information about you, such as recent lab or x-ray reports.
  - Your health care provider may not have a complete summary of all of your medications and any medication allergies or reactions you had in the past.
  - If you later decide to change a prior election, your health record may not be as complete and up to date.

  Even if you opt out of participation in the NDHIN, a treating health care provider will still be able to select the NDHIN as a way to receive your lab results, radiology reports, and other data sent directly to any treating health care provider that the provider may have previously received by fax, mail, or other electronic communications.

- Your decision to opt out of participation in the NDHIN will not prevent a health care provider from disclosing your Protected Health Information to the extent required by law and the use or disclosure complies with and is limited to the relevant requirements of those laws (for example, immunization records of minors and required public health reporting). However, any reported information required by law will not be available to other health care providers except as permitted by law.

- To maintain a record of your choice to opt out of participation in the NDHIN, your name and limited identifying information will be kept in the NDHIN index.

- Any health information provided through NDHIN before opting out of participation will only be available to your health care provider.

Please place an "X" by one of the following options:

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|---|---|
| | I do not want to participate in the NDHIN, even in the case of an emergency. |
| | I do not want to fully participate in the NDHIN, but my health information may be accessed and disclosed in the case of a medical emergency. |
| | I want to fully participate in the NDHIN and am revoking my prior opt out choice. |

"Medical emergency"* means "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

(1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or
(2) serious dysfunction of any bodily organ or part."

| Printed Name (Full Name, including Middle Name) | | | Date of Birth |
|---|---|---|---|
| Mailing Address | City | State | ZIP Code |
| Signature of Patient or Patient's Legal Representative | | | Date |

* EMTALA definition