

## ILHIE's EHR Connect Opt-Out Form

The Illinois Health Information Exchange's ("ILHIE's") EHR Connect ("EHR Connect") service is a Statewide, secure electronic network that uses modern technology so that your doctors, specialists, hospitals, clinics, laboratories, pharmacies and health insurance plans ("EHR Connect Users") can share a summary of your electronic health information for authorized purposes like assisting with your treatment, payment and health care operations. To learn more about ILHIE's EHR Connect, visit [HYPERLINK to website]. Please read the "Notice to Patients Regarding the Illinois Health Information Exchange's EHR Connect" then, **if you decide you want to opt out of ILHIE's EHR Connect, complete and sign this form.**

### I Choose to Opt-Out of ILHIE's EHR Connect.

By signing below, I confirm that I want to opt out of ILHIE's EHR Connect. By choosing to opt out, I understand that none of my health information from my health care provider will be available through ILHIE's EHR Connect to other ILHIE EHR Connect Users, even in the case of a life-threatening emergency. I understand that, even if I opt out of sharing information through ILHIE's EHR Connect, my health information that is shared as permitted by law, such as public health data, may still be shared through the ILHIE.

I understand that I can change my mind at any time and participate in ILHIE's EHR Connect by completing the "ILHIE's EHR Connect Opt-In Form," available from my health care provider or at [HYPERLINK to website].

Please Note: Opting out of ILHIE's EHR Connect does not mean that you have opted out of participation in any other health information exchange. Ask your health care provider if they participate in any other health information exchanges and if you need to complete an additional opt-out form. Questions? Please contact [ILHIE.Privacy@illinois.gov](mailto:ILHIE.Privacy@illinois.gov)

### Complete all of the following information:

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Previous Last Name: \_\_\_\_\_ Birth Date: (Ex. 01/01/1990) \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number 1: \_\_\_\_\_ Phone Number 2: \_\_\_\_\_

Email Address: \_\_\_\_\_ Last Four (4) Digits of Social Security Number (if available): \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If the patient is 12 years of age or over, the patient must sign the form. If the patient is 11 years of age or under, the patient's parent or legal guardian must sign the form. (Check, if applicable:  Parent  Legal Guardian.)

**Submission of form:** You may submit this form one of two ways:

Option 1: Give this completed form to your health care provider, or

Option 2: Complete the form and have the form notarized (below). Then send the form to the ILHIE Authority. The ILHIE Authority will make every effort to process your request to participate within 3 business days of receiving this form by one of the following means:

- Mail: Privacy Officer  
Illinois Health Information Exchange Authority  
James R. Thompson Center  
100 W. Randolph Street, Suite 40XXX  
Chicago, IL 60601
- Facsimile : 312-814-1468
- Scan and email: [ILHIE.Privacy@illinois.gov](mailto:ILHIE.Privacy@illinois.gov)

If using Option 2, the following section must be completed by a Notary Public:

I witnessed the above individual sign this document and the individual provided me with picture identification on this, the \_\_\_\_ day of \_\_\_\_, 20 \_\_\_\_.

Printed Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Seal: \_\_\_\_\_