

Opt – Out Request Form

The Illinois Health Information Exchange's (ILHIE's) EHR Connect service is a statewide, secure computer network for sharing a patient's health information between health care providers to improve their care. To learn more about EHR Connect, visit ([Tiny URL Address Needed](#)).

I Choose Not to Participate in ILHIE's EHR Connect (Opt-Out)

I request that all my medical information be blocked from the ILHIE EHR Connect service. I understand that not participating in EHR Connect means that my medical information will not be available or searchable to my health care providers even in the case of a life threatening emergency.

I understand that I may change my mind at any time and opt back in to EHR Connect by completing the Opt-Back-In form, available from my health care provider or at ([Tiny URL Address Needed](#))

Instructions: The following information is needed to make sure that the correct person is removed from EHR Connect. A separate form must be filled out for each person choosing to opt-out.

First Name: _____ Middle Name: _____ Last Name: _____

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

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number 1: _____ Phone Number 2: _____

Email Address: _____ Last Four (4) Digits of Social Security Number: _____

Patient Signature: _____ Date: _____
(If under 18 years of age, signature of parent or legal guardian)

ILHIE will process your request not to participate within XX business days of receiving this form

Please Note: Opting out of the ILHIE's EHR Connect service does not mean that you have opted out all Illinois Regional Health Information Exchanges

Questions? Please contact ILHIE.Privacy@illinois.gov

You may give this completed form to your health care provider or send it to the ILHIE Authority to process. If submitting to the ILHIE Authority, for your protection, the ILHIE Authority requires you verify your identity by having this form signed by a notary public.

Please submit this completed and notarized form to:

- By mail:
 - Privacy Officer
 - Illinois Health Information Exchange
 - James R. Thompson Center
 - 100 W. Randolph Street, Suite 40XXX
 - Chicago, IL 60601
- By FAX : 312-814-1468
- By scanning and emailing: ILHIE.Privacy@illinois.gov

Notary Form:

This 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: _____