

Great Lakes Health Information Exchange Participation Change Request

This form allows you to limit electronic access of your health information. The HIPAA Privacy Rule permits the use and disclosure of Protected Health Information for purposes of treatment, payment and operations. GLHIE is an electronic health information exchange service which your treating providers use to share health information about you. Your health information will be available electronically to your treating providers unless you decide to opt out and not have your information shared electronically. Even if you decide to opt out of data exchange via GLHIE, some legally permissible identifiable health information will still be transferred electronically.

If you Opt Out, your treating providers will not be able to access your health information by making an electronic inquiry through the GLHIE system except in the case of a medical emergency. You have the option to change your mind and terminate your Opt Out decision. You have a right to a copy of this form.

If you signed as a legal representative, all references in this form refer to the patient.

Instructions: Check **only one** box and **provide all of the requested information below**. Please print. Sign and date the form.

I choose to Opt Out. I do not want my authorized health care providers to access my health information by making an electronic inquiry through the GLHIE system.

OR

Request to terminate my previous decision to opt out.

I want to reverse my previous decision to opt out. By completing and signing this form, I am allowing my health information to be accessible to my authorized health care providers through GLHIE, unless restricted by applicable state or federal laws.

Patient Name _____ Gender M F
Last First Middle Initial (circle one)

Date of Birth ____/____/____ Previous or Other Last Name _____
(MM/DD/YYYY)

Address: _____
House or Apartment Number and Street

City _____ State _____ Zip Code _____

Legal Representative (if applicable) _____

Relationship to Patient _____

Signature of Patient or Legal Representative _____ Date (MM/DD/YYYY) _____

Reason, if other than patient: Patient is incapacitated

Patient is a minor

The portion below is to be completed by Health Care Provider. Please be sure all information above has been completed by the patient.

PLEASE FAX TO GLHIE AT 517-347-3387 THE SAME DAY

Name of Health Care Provider _____ Phone _____

Address: _____ Fax _____

Date form entered into electronic system by GLHIE: ____/____/____ (MM/DD/YYYY)