Dear Patient:

C3HIE (Connected, Collaborative, Community) is a faster and more secure way for health care providers such as doctors, hospitals, labs, and x-ray facilities to share patient health information. C3HIE is not a complete record of your health history. It is a way for health care providers to quickly get the medical information they need to provide you with better care.

C3HIE is Good for You and Your Doctor:

- C3HIE is a **secure** way for your doctors to get the most up-to-date medical information about you. Only those caring for you will be allowed to see your test results and other medical information. For patients who participate, information that could help save your life in a medical emergency is available to emergency doctors at participating hospitals.
- C3HIE **improves care** by sending results to your doctor quickly and securely. C3HIE can also help your doctors refer you to a specialist so that you can get an appointment faster.
- C3HIE **saves you time and money**. If a specialist needs you to have tests done before your visit, your doctor can send you for the tests *before* you go to the specialist(s). Because your doctor will have this information before you come in for your appointment, you won't have to repeat tests or carry medical records with you to appointments.
- C3HIE **protects privacy** by having security safeguards and standards in place to protect your information. Your doctors can send information to other doctors without using phone calls, mailing or faxing, and only the correct, authorized health care staff will see your information. C3HIE can also track who has looked at your information – making your health information more secure.

Opt-Out Option:

Patients who do not want their medical information to be accessible to authorized health care providers through C3HIE may choose to "opt-out". If you choose to opt-out, health care providers will not be able to look for your records in C3HIE, including in a medical emergency.

If you want to opt-out of C3HIE, you must complete the attached Opt-Out Request form. For your protection, your identity must be verified by having this form signed by a Notary Public. The completed form, with original signatures in black or blue ink, must be mailed to: **C3HIE, 5535 Fredericksburg Rd, Suite 220, San Antonio, TX 78229**.

By completing the form, you are only preventing health care providers from searching for your information through C3HIE. Your medical records will still be available to your health care providers from sources outside of C3HIE.

If you have any questions, please contact C3HIE by phone: (210) 257-6284, email info@C3HIE.org, or visit the website at www.C3HIE.org.

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Opt-Out Request Form

for C3HIE Health Information Exchange

Please initial that you have read and understand each of the following statements.

_____ Initial
I understand that by submitting this *Opt-Out Request Form* my protected health information will not be accessible to participating health care providers through C3HIE, including in a medical emergency.

_____ Initial
I hereby authorize C3HIE to block participating health care providers from searching for my medical information through C3HIE.

_____ Initial
I understand that this request does not prevent authorized health care providers from disclosing my medical information directly to each other by other permitted methods, such as secure email, fax or mail.

_____ Initial
I understand that I may choose to participate in C3HIE again at any time by completing a *Cancellation of Opt-Out* form.

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

Previous/Maiden Last Name: _____ Date of Birth: _____ (MM/DD/YYYY) Sex: ☐ Female ☐ Male

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone 1: _____ Phone 2: _____

Email Address: _____ Last Four (4) Digits of Social Security Number: _____ (xxx-xx-1234)

Patient Signature or Legal Rep.: **X** _____ Date Signed: _____
(If under age 18 years, signature of parent or legal guardian)

For your protection, we must verify your identity in order for C3HIE to process the *Opt-Out Request*. Your identity must be verified by having this form signed by a Notary Public.

This form must be mailed to C3HIE with original signatures in black or blue ink.

Section to be completed by a Notary Public:

I witnessed the above named individual or their legal representative sign this document and the individual is personally known to me and/or provided me with valid picture identification on this _____ (Day) day of _____ (Month), 20 _____ (Year).

Notary Name (print): _____

Notary Signature: **X** _____
Must be an original signature in black or blue ink.

Phone Number: _____ Date Signed: _____

My Commission Expires: _____

Notary Seal

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