Provider Location: ____________________

# HASA OPT-OUT REQUEST FORM

***HEALTHCARE ACCESS SAN ANTONIO (HASA)***

I understand that participation in a Health Information Exchange (HIE) is voluntary and that if I do not want to participate I can choose to opt-out of having my health information viewable, which will include **not** making my information available in emergency situations. If I opt to not have my information shared, my ability to receive health care **will not** be affected.

*Please check all boxes below indicating that you have read and understand each of the following statements.*

☐ **I understand that by submitting this *HIE Opt-Out Request Form* and selecting this choice, my health information will *not* be viewable in the HASA HIE system or viewable by any health care providers through the HASA HIE system.**

☐ **I understand that by submitting this HIE OPT-OUT Request Form and selecting this choice my health information WILL NOT be viewable in an emergency.**

☐ **I understand that I am free to revoke this Opt-Out Form at any time and can do so by completing a *HASA Health Information Exchange (HIE) Revocation of Opt-Out Form* that can be obtained from HASA's website at www.hasatx.org/community/pdf or from my health care provider.**

☐ **I understand that this request only applies to sharing my health information through the HASA HIE system. I recognize that when I see a health care provider for treatment that provider may request and receive my medical information from other providers using other methods permitted by law, such as fax or mail.**

A separate form must be filled out for each family member requesting to opt out. **ALL FIELDS NEED TO BE COMPLETED** for this form to be processed. A contact phone number is required in case HASA needs to contact you to ensure accuracy of your demographic information.

| ***Patient Last Name*** | ***First Name*** | ***Middle Initial*** | ***(Previous Names/Nicknames)*** |
|---|---|---|---|
| ***Mailing Address*** | ***City,*** | ***State*** | ***Zip Code*** |

( ) -

**Contact Phone Number** | ***Social Security # (Last 4 digits)*** | ***Date of Birth (mm/dd/yyyy)***

Signature of Patient ____________________ Date Signed ____________________

Signature of Parent/Guardian ____________________ Date Signed ____________________

*If patient under 18 years, signature of patient guardian*

Parent/Guardian Name ____________________ Parent/Guardian Contact Telephone ____________________

☐ Parent ☐ Guardian ☐ Other____________________

## Section to be completed by a Notary Public or Health Care Provider (or office staff):

I witnessed the above named individual signing this document and the individual is personally known to me or provided me with valid picture identification on this day _____of__________, 20____.

Notary or Provider Signature: ____________________ Phone Number: ____________________

Print Name: ____________________ Date Signed: ____________________

*(Must be original signature in black or blue ink)*

***PRACTICE ADMINISTRATOR: Please send the completed form via HASAReferral to "HASA consent forms-sent here" (searchable in Location tab) or fax to 210-918-1376***