CANCELLATION OF PRIOR TRENTON HIE OPT OUT FORM

Name: _____

Date of Birth: _____ / _____ / _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **E-mail Address:** _____

I hereby acknowledge and agree as follows:

1. I WISH TO cancel my prior decision to Opt Out of the Trenton HIE, and now I specifically AUTHORIZE my information maintained in the Trenton HIE to be electronically available to my providers;

2. I UNDERSTAND that by making this selection, now ALL of my authorized providers who participate in or are connected to the Trenton HIE will have access to my health information maintained in the Trenton HIE;

3. I UNDERSTAND that by making this selection, my health information may be accessible by other HIEs with whom the Trenton HIE participate;

4. I UNDERSTAND that this cancellation can only be changed if I specifically submit a new Trenton HIE Opt Out form;

5. I have had an opportunity to have all my questions regarding this Cancellation of Prior Trenton HIE Opt Out and any others answered; and

6. This request can take up to 3 business days to take effect.

Signature: _____ **Date:** _____

If Legal Representative, state Authority: _____

This completed and signed form can be faxed to (609) 256-4554, emailed to thie@trentonhealthteam.org, or mailed to:

Trenton Health Team
Attn: Trenton HIE Administrator
1 West State Street – Floor 4
Trenton, NJ 08608