ICHS International Community HEALTH SERVICES

Patient's Chart Label

ICHS EPIC CARE EVERYWHERE PATIENT OPT-OUT FORM

ICHS participates in a Health Information Exchange (HIE) through Epic Care Everywhere that allows health organizations/facilities who utilize Epic as their electronic health care record to exchange electronic health information. The electronic health record is shared through secure, electronic means and follows such providers to have the most recent available information to care for you as a patient.

You may opt out if you do not want your health information to be shared with your treating provider(s) through Epic Care Everywhere. If you opt out, you also have a right to opt back in at any time by completing this form.

Patient Information (All sections required - please print clearly)

Name (Last, First, Middle Initial): _____ Date of Birth:_____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Email Address: _____

☐ **Request to Opt-Out**: I request that my health information is excluded from Epic Care Everywhere.

- I understand this means that other care teams will not be able to obtain my health information through Epic Care Everywhere. My care team can still obtain my medical records through other methods.
- I understand that any information that was shared through Epic Care Everywhere previously will remain available to providers who have access unless I request to remove the previous record by marking the box below and initial at the line
    - o Remove the previous record _____ *(Initial here)*.
- I understand by opting out my care team will no longer be able to obtain records from outside providers (including hospitals and facilities) using Epic Care Everywhere. Records will need to be requested manually.
- I understand that opting out of Epic Care Everywhere may cause delay with my health information being disclosed to outside providers, including in emergency situations.
- I understand that opting out of Epic Care Everywhere at one ICHS clinic site will also opt-out for all other ICHS sites.

☐ **Request to Opt Back In**: I request to cancel my previous decision to opt-out. By completing and signing this form, I am allowing my health information to be shared with my non-ICHS health care providers/health organizations/facilities and hospitals through Epic Care Everywhere as permitted or required by federal or state law

- I understand that rescinding my request to opt-out at one ICHS clinic site will also rescind the opt-out for all other ICHS sites.

Please allow up to 7 business days after receipt for processing this form

Patient (or legal guardian) Signature	Date:	Time:
Patient Name (Printed)	Legal Guardian printed name (if applicable):	

(*Continued next page*)

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You can either mail or fax this completed form to your preferred location below:

☐ International District Medical & Dental Clinic P.O Box 3007 Seattle WA, 98114 Attn: Medical Records Phone: (206) 788-3712 Fax: (206) 962-3297	☐ ICHS Legacy House 803 S Lane St Seattle, WA 98104 Phone: (206) 292-5184 Fax: (206) 292-5271	☐ ICHS Vision Clinic P.O Box 3007 Seattle WA, 98114 Phone: (206) 788-3505 Fax: (206) 962-3302
☐ Bellevue Medical and Dental Clinic 1050 140th Ave NE Bellevue, WA 98005 Attn: Medical Records Phone: (425) 373-3012 Fax: (425) 259-8639	☐ Holly Park Medical and Dental Clinic 3815 S. Othello Street -2nd Fl Seattle, WA 98118 Attn: Medical Records Phone: (206)-788-3541 Fax: (206)- 962-3298	☐ Shoreline Medical and Dental Clinic 16549 Aurora Ave N Shoreline, WA 98133 Attn: Medical Records Phone: (206) 533-2612 Fax; (206) 962-3299
☐ Seattle World School Teen Health Center 1700 East Union St Seattle, WA 98122 Phone: (206) 332-7160 Fax: (206) 568-7128	☐ Highland Middle School Health Center 15027 NE Bel-Red Rd Bellevue, WA 98007 Phone; (425) 373-3135 Fax: (425) 373-3134	

ICHS Staff ONLY

Date Received: _____

Processed By: _____

Completed Date: _____