Epic Care Everywhere Patient Opt-Out

EvergreenHealth participates in a Health Information Exchange (HIE) through Epic Care Everywhere that allows health organizations who utilize Epic as their electronic health record system to exchange electronic health information. This information is shared through secure, electronic means and allows 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 or received by your treating provider(s) through Epic Care Everywhere. If you opt out, you also have the right to opt back in at any time by completing this form.

Patient Name: _____ Birthdate: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email Address: _____

☐ **Request to Opt-Out of Sharing:** I request that my health information be excluded from EvergreenHealth sharing it through Epic Care Everywhere.

☐ **Request to Opt-Out of Receiving:** I request that my health information be excluded from EvergreenHealth receiving it through Epic Care Everywhere.

Impact of opting out of sharing and/or receiving my health information through Epic Care Everywhere:

- I understand this means that healthcare providers will not be able to obtain my health information through Epic Care Everywhere. My healthcare providers 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.
- I understand that opting out of Epic Care Everywhere may cause a delay with my health information being disclosed to providers, including in emergency situations.

☐ **Request to Cancel (Rescind) Opt-Out of Sharing**: 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-EvergreenHealth providers through Epic Care Everywhere as permitted or required by federal or state law.

☐ **Request to Cancel (Rescind) Opt-Out of Receiving**: I request to cancel my previous decision to opt out. By completing and signing this form, I am allowing my health information to be received by EvergreenHealth providers through Epic Care Everywhere as permitted or required by federal or state law.

Signature: _____ Date: _____

(If signed by a personal representative of the patient, please complete the following)

Personal Representative's Name: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian* ☐ Power of Attorney* ☐ Executor of Estate*

*Attach Legal Documentation if you are the Legal Guardian, Power of Attorney or Executor of Estate

Send completed forms to: Health Information Management (HIM) – MS 49, 12040 NE 128th St, Kirkland, WA 98034.

EvergreenHealth Staff Only:

Date Received:

Processed by:

MR