HOAG MEMORIAL HOSPITAL PRESBYTERIAN
One Hoag Drive, PO Box 6100
Newport Beach, CA 92658-6100

PATIENT OPT-OUT REQUEST FORM

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

Initials:_____ I have read and understand the Patient Opt Out Request Informational Sheet that has been provided to me.

Initials:_____I understand that not participating in Hoag's HIE means my medical information will not be accessible to health care providers, including emergency personnel, through a query or expanded query of Hoag's HIE.

Initials:____I hereby authorize Hoag's HIE to block query access to my medical information in Hoag's HIE.

Initials:_____I understand that I may choose to participate in Hoag's HIE again at any time by submitting a Reinstatement of contacting Hoag's Health Information Exchange Department

Please provide the following information:

First Name:_____

Middle Initial:_____

Last Name:_____

Date of Birth:_____

Street Address:_____

City:_____

State:_____

Zip Code:_____

Daytime Phone Number:_____

Email Address:_____

Patient Signature:_____Date_____
(If under 18 years of age, signature of parent or legal guardian)