Department of Veterans Affairs

OPT-OUT OF SHARING PROTECTED HEALTH INFORMATION THROUGH HEALTH INFORMATION EXCHANGES

By completing this form, you are requesting to be opted out of health information exchanges (HIE) for treatment purposes. HIE allows health care professionals and patients to access and securely share a patient's protected health information electronically. HIE enables VA to share patient information with community providers and other HIE partners. Opt-out means that none of your health information can be shared through HIE for your treatment except in a life-threatening medical emergency. If you are an Active Duty Servicemember, DoD may not permit you to Opt-out of HIE. Opt-in means that all of your health information can be shared through HIE for your treatment. Your disclosure of the information requested on this form is voluntary. A decision to complete the form will not have any effect on any benefits to which you may otherwise be entitled, however, you will not be able to participate in HIE. Because VA uses the Social Security Number (SSN) to electronically locate patient records, you need to provide your complete and accurate SSN in order for us to carry out your request to opt-out.

PRIVACY STATEMENT: Your disclosure of the personal information requested on this form is voluntary. However, if the information containing the Social Security Number (SSN) (the SSN will be used to locate records) is not furnished completely and accurately, the Veterans Health Administration (VHA) will be unable to comply with your request. By completing this form, you will be opted out of the electronic exchange of health information for treatment purposes. Failure to furnish the personal information will not have any effect on any other benefits to which you may be entitled; however, you will not be opted out of information exchange. Consistent with the VA Notice of Privacy Practices, VA may also use the information on this form for purposes other than your treatment as authorized or required by law. The information collected on this form is part of a Privacy Act system of records. "Health Information Exchange-VA", 168VA005. The personal information requested on this form is solicited under Title 38, U.S.C. 501.

FULL NAME:					
LAST (Print)	FIRST		MIDDLE	9	9-DIGIT SSN
OPT-OUT				<u>.</u>	
By signing this form, I understand that I am dipartners. By signing this form, I am agreeing the HIE for their treatment of me except in a life-the treatment on paper or through fax or other leg freely, voluntarily, and without coercion. This is to HIE in writing on VA Form 10-10163.	that my health inform nreatening medical pally allowed means	mation will no lor emergency. My l other than HIE.	nger be shared electhealth information was a certify that I am m	ctronically with pwill continue to naking this opt-	partners through be shared for my out request
If you decide that you would like to be opted but Information Office at the VA Medical Center was 1-877-771-VLER (8537).			· •		
SIGNATURE:					
Signature of Patient (sign in ink)		Date (MM/DD/YYYY)		
Signature of Legal Representative (if applicable) (sign in ink)			Date (MM/DD/YYYY)		
To Sign for Patient (Attach authority to sign: Healt	th Care Power of Atto	orney or Legal Gu	ardian)		
Name of Legal Representative (please print)					

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