ColumbusConnect

Request for Opt-Out

By signing and submitting this form, you are agreeing that you have read and understand the following conditions to which you are requesting to opt-out of participation within the ColumbusConnect.

- I understand that by submitting this form, my personal health information will no longer be viewable by providers, including emergency room physicians (unless an emergency exception applies), using ColumbusConnect. In understanding the ramifications of my decision, I choose to prevent access to my personal health information through the ColumbusConnect.
- I may only request to opt-out for myself or for those minor children (up to 18 years of age) of whom I am the parent or legal guardian.
- I fully understand that opting-out of this electronic exchange system in no way prevents my authorized treatment provider(s) from properly using or disclosing my healthcare records and information directly with each other by other permitted methods, such as by fax, mail, or the like.
- I acknowledge that I will be allowed to make my personal health information available again in the ColumbusConnect by completing the Cancellation of Opt-out Request Form found on the ColumbusConnect website or as provided by my participating healthcare provider.

First Name: _____ Middle Name: _____ Last Name: _____

Previous Last Name: _____ Date of Birth: _____ (Ex: 01/01/1990) Gender: Female Male

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone 1: _____ Phone 2: _____

Email Address: _____ Last Four (4) Digits of Social Security Number: _____ (Ex. xxx-xx-1234)

Patient Signature: X_____ Date Signed: _____
(If under age 18 years, signature of parent or legal guardian)

This form must be returned to ColumbusConnect with original signatures in black or blue ink in one of the following ways:

Fax To: 910-641-8371
Email To: stodd@crhealthcare.org
Mail To: ColumbusConnect
500 Jefferson Street
Whiteville, NC 28472