Instructions for Completing: Cancellation of Opt-Out Request

Dear Patient:

You previously submitted a request to opt-out of CommonWell. We have since received a request from you letting us now you would like to begin participating again (Opt-In) in CommonWell Health Information Exchange.

By submitting a *Request for Cancellation of Opt-Out* form, your test results and medical information will be accessible to authorized health care providers through CommonWell. This includes any test or other medical information that was generated while you were opted out. In order to begin participating in CommonWell, please complete the attached *Request for Cancellation of Opt-Out* form.

CommonWell can benefit you and your doctor

The HealthCare Information Exchange (CommonWell) provides a secure and fast exchange of test results and other medical information to participating hospitals, labs, x-ray facilities and doctors who participate. CommonWell is *not* a complete record of your health history. It is simply a way for health care providers that participate in this exchange to access the medical information they need to provide you with better care.

- CommonWell is a **secure** way for your doctor to get the most up-to-date medical information about you.

  For example, information that could help save your life in a medical emergency will be available to emergency room (ER) doctors at participating hospitals. Only health care providers with a valid reason will be allowed to see your test results and other medical information.
- CommonWell **protects privacy** by having safeguards in place to protect your information.

If you have any questions, please contact CRHS Medical Records:

- Call 910-642-8011 ext. 2281
- Visit the website: www.crhealthcare.org; click on the Commonwell link

Thank you for choosing to participate in CommonWell!

Request for Cancellation of Opt-Out CommonWell

By signing and submitting this form you are indicating that you have read and understand the following conditions to which you are requesting to reinstate participation within the CommonWell and the ability for healthcare providers to view your personal health records electronically.

- I had previously chosen not to participate in CommonWell and completed a Request for Opt-Out Form.
- I understand that by submitting this form, my personal health information will now be viewable by providers within CommonWell, including emergency room physicians.
- I understand the information generated while I was opted out will not be included in the information that will be viewable in the CommonWell.
- I hereby authorize CommonWell to cancel my request for Opt-Out of the CommonWell Community.
- I am requesting to opt-in for myself or for those minor children (up to 18 years of age) of whom I am the parent or legal guardian.
- For your protection, Columbus Regional requires you verify your request by completing the form and **signing it in blue or black ink**.

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 <u>must be returned</u> to Columbus Regional with original signatures in one of the following ways:

Fax To: 910-642-9302
Email To: crhshim@crhealthcare.org
Mail To: CRHS Medical Records 500 Jefferson Street, Whiteville, NC 28472