HEALTH INFORMATION EXCHANGE OPT-OUT/ OPT-IN FORM

Indian Health Board of Minneapolis, Inc.
1315 East 24th Street, Minneapolis, MN 55404
Main: 612.721.9800 | Fax: 612.721.2904

Please place a "✓" by one of the following options:

☐ HIE Opt-Out: I do not want my health information shared in the HIE

- If you opt-out, this may limit the information available to your health care provider which could affect treatment options and health care decisions.
- Your decision to opt-out will not affect the sharing of your health information between your health care providers and health insurers via other methods, such as fax, mail, etc.
- Your decision to opt-out of participation in HIE will not prevent a health care provider from disclosing your health information as required or permitted by law.

☐ HIE Opt-In: I want to change my opt-out choice and have my health information shared in the HIE

Patient Information

Printed Name (Last Name, First Name, Middle Name)			Date of Birth / /
Mailing Address	City	State	Zip Code
E-Mail Address			Telephone Number ( ) -

Patient's Legal Representative (if applicable)

Printed Name of Legal Representative

Signature

Signature of Patient or Patient's Legal Representative	Date / /

It may take up to five (5) business days to process this request.

Any changes to this form must be reviewed and approved by Health Information Management

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