Northeast Georgia Diagnostic Clinic
Since 1953
A Northside Network Provider

REQUEST TO OPT-OUT OF HEALTH INFORMATION EXCHANGE FORM

Please complete, sign, and email this form to optout@ngdc.com
or bring this form to our front desk staff.

Full Patient Name (*print*): _____ DOB: _____

Street Address: _____

City: _____ State: _____ Zip: _____

A Health Information Exchange ("HIE") is designed to allow participants (hospitals, physician practices, labs, pharmacies, and others) to share health information efficiently and securely by electronic means to better coordinate your healthcare needs. Participating in the HIE may allow for the more efficient exchange of health information as compared to faxing or transporting paper medical records between your providers. Your participation in the HIE is voluntary and subject to your right to opt-out. Your receipt of treatment will not be conditioned on whether or not you choose to participate in the HIE.

By completing this form, you have considered your option to participate in the HIE(s) chosen by Northeast Georgia Diagnostic Clinic and elected to OPT-OUT of participation. By choosing to OPT-OUT, you hereby acknowledge and agree as follows:

- Your health information will no longer be accessible by other participants through the HIE as of the date your opt-out request takes effect.
- Opting out of the HIE may delay access to important health information, which could limit your provider's ability to make the best possible decisions about your care, including in an emergency situation.
- Your health information may not be viewable through the HIE, but will continue to be available to your treating providers through previously established methods, such as phone, fax, or mail.
- Requests to opt out may take several days to honor and will not apply to any information exchanged with other HIE participants before that date.

By signing below, you understand and agree to the terms of this document. If you are signing on behalf of the patient, you are signing in a representative capacity and affirm that you have the legal authority to agree to these terms on behalf of the patient and bind the patient to these terms.

Only complete if patient unable to sign:

_____
Signature of Patient or Legally Authorized Representative

_____
Printed Name

_____
Date

_____
Relationship to Patient

_____
Reason Patient Unable to Sign