Inova™

CEOPT

Inova participates in a Health Information Exchange (HIE) through Epic Care Everywhere that allows health organizations who utilize Epic as their electronic health record system to exchange electronic health information. This information is shared through secure, electronic means and allows providers to have the most recent available information to care for you as a patient. You may opt out if you do not want your health information to be shared with or received by your treating provider(s) through Epic Care Everywhere. By completing this form if you opt out, you also have the right to opt back in at any time by resubmitting this form.

Patient First Name: _____ **Patient Last Name:** _____

Date of Birth: _____ **Address:** _____

City: _____ **State:** _____ **Zip code:** _____

Phone Number: _____ **Email Address:** _____

Impact of opting out of sharing and/or receiving my health information through Epic Care Everywhere:

- I understand that this means healthcare providers will not be able to obtain my health information through Epic Care Everywhere. My healthcare providers can still obtain my medical records through other methods.
- I understand that any information that was shared through Epic Care Everywhere previously will remain available to providers who have access.
- I understand that opting out of Epic Care Everywhere may cause a delay with my health information being disclosed to providers, including in emergency situations.
- I understand that by opting out, I am stopping future electronic sharing of my health information through Care Everywhere. This does not affect information already shared. If I have concerns about previously shared data, I will contact the organization that received it.

☐ **Request to Opt-Out of Sharing:** I request that my health information be excluded from Inova sharing it through Epic Care Everywhere.

☐ **Request to Opt-Out of Receiving:** I request that my health information be excluded from Inova receiving it through Epic Care Everywhere.

☐ **Request to Cancel (Rescind) Opt-Out of Sharing:** I request to cancel my previous decision to opt out. By completing and signing this form, I am allowing my health information to be shared with my non-Inova health providers through Epic Care Everywhere as permitted or required by federal or state law.

☐ **Request to Cancel (Rescind) Opt-Out of Receiving:** I request to cancel my previous decision to opt out. By completing and signing this form, I am allowing my health information to be received by Inova health providers through Epic Care Everywhere as permitted by or required by federal or state law.

Patient/Designated Decision Maker (DDM) (signature): _____ Date: _____ Time: _____

If signed by a DDM of the patient, complete the following:

DDM (print name)**:** _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian ☐ Power of Attorney ☐ Executor of Estate

Attach legal documentation if you are the Legal Guardian, Power of Attorney, or Executor of Estate.

Send completed form(s) to: Health Information Management (HIM) Fax Number**: 703-776-2904**

Interpreter Information (To be completed by Inova staff, if applicable)**:**

☐ In person ☐ Telephonic ☐ Video Interpreter name/ID number (if applicable) _____

☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Epic Care Everywhere Patient Opt-Out/Opt-In

☐ IAH ☐ IFH ☐ IFOH ☐ ILH ☐ IMVH

☐ Outpatient Location: _____

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