HealthInfoNet

# Opt-out Form

(to **not** share general health information)

**If you want to share your health information through HealthInfoNet, you do not need to do anything with this form.**

**What is HealthInfoNet?**
HealthInfoNet is a secure computer system that brings your health information from different healthcare providers into one statewide electronic health record. Your providers use this information to make better decisions about your care. It can also help them prevent mistakes, especially in an emergency. Your health record includes information about your medicines, allergies, test results, and more.

**Are my records private and secure?**
HealthInfoNet encrypts all information and sends it over secure computer connections. Only those involved in your care can look at your information. To find out who has looked at your record and when they looked at it, go to www.hinfonet.org/audit. Of course, no system is completely secure, but HeathInfoNet makes every effort to keep your records safe.

**What does it mean to "opt-out"?**
If you do not want your health information in a HealthInfoNet record, fill out this form to "opt-out", or not share your health information. Your choice to opt-out will not affect your ability to get medical care. If you decide later that you want to have a HealthInfoNet record, you will need to call HealthInfoNet or fill out an "opt-in" form on the HealthInfoNet website at www.hinfonet.org/yourchoices

## I choose not to share my health information

Fill out this form and mail it to HealthInfoNet, 125 Presumpscot Street, Box 8, Portland, ME, 04103 or fax it to 1-207-541-9258,
Or fill this form out online at www.hinfonet.org/yourchoices
If you have questions, call HealthInfoNet at 1-866-592-4352 or 207-541-9250, or email us at info@hinfonet.org.

_____

First Name | Middle Name | Last Name

_____

Address | City | State | Zip Code

Sex: ☐ Male ☐ Female

Date of Birth: _____/____/ _____ (month / day / year )

__ __ __ – __ __ – __ __ __ __ Social Security Number (not required)

_____ _____

Phone Number | Email

***By signing, I understand that my health information will not be available to providers using HealthInfoNet, even in an emergency.***

_____ _____ / ____ / _____

**Signature of Patient or Guardian** | **Date** (month / day / year )

This notice is provided as required by Maine State Law.