HealthInfoNet

Opt-Out Revoke Form

(to **share** general health information after previously opting-out)

If you have previously opted-out, and now you want your caregivers to share your medical information using HealthInfoNet, you'll need to opt-in.

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-in"?
If you have previously opted-out, and now want your health information in a HealthInfoNet record, fill out this form to "opt-in". Your health record will begin to populate as of the date of this form, but does not include data collected during the time you had opted-out. If you decide later that you want to opt-out, you will need to call HealthInfoNet or fill out an "opt-out" form on the HealthInfoNet website at www.hinfonet.org/yourchoices.

I choose 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 _____

_____ Signature of Patient or Guardian ***required***

_____/_____/_____ Date (month / day / year)

_____ Witness Signature ***required***

_____ Witness Print Full Name ***required***

_____ Healthcare Organization ***required***

On ___/____/_____, I attest that the above signer is personally known to me or established his/her identity by presenting government-issued photo identification.

This notice is provided as required by Maine State Law.