**Practice Name**

PRODUCT NAME Patient Portal Opt-Out Form

Name: ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: State: Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ e-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRODUCT NAME is a HIPAA compliant, electronic health record (EHR) application physician offices and other health care providers utilize on a daily basis so as to provide accurate, modern, electronic patient care. An EHR is an important aspect of physician’s daily routine and allows the practice to successfully achieve standardized systems of care as regulated by CMS, et. al. PRODUCT NAME EHR providers our practice the ability to provide higher quality services, better outcomes, lower costs and happier, healthier patients.

After considering my option of participating in PRODUCT NAME Patient Portal, I have decided to OPT OUT and NOT participate. By choosing to OPT OUT of the PRODUCT NAME Patient Portal, I hereby acknowledge and agree as follows:

1. Opting out of the Patient Portal may delay access to important medical information.

2. My health information will not be shared among health care providers through the PRODUCT NAME . Instead, my providers will continue to share my information via previously established methods, such as phone, fax, or mail.

3. My health information will NOT be shared with outside organizations.

4. Any information that is shared before I submit this Patient Portal Opt-Out form may remain with providers who accessed information before this Opt-Out went into effect.

5. My EHR Opt-Out selection will remain in effect unless I change it in writing; and

6. This request can take up to 3-5 business days to take effect.

If this form is signed by someone other than the person named above, the person signing the form hereby certifies that he/she is acting as: (Check One) \_\_\_\_ Parent \_\_\_\_ Legal Guardian \_\_\_\_

Other (Specify Relationship) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for the person named above.

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please forward the completed and signed Patient Portal Opt-Out Forms to PRACTICE NAME by one of the following:

Provide in person, Fax to: (000) 000-0000 or Email to: