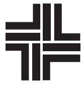

PLACE PATIENT LABEL HERE

UI HEALTH EPIC CARE EVERYWHERE PATIENT OPT – OUT FORM

The University of Illinois Hospital & Health Sciences System (UI Health) participates in a Health Information Exchange (HIE) through Epic Care Everywhere that allows non-UI Health organizations and healthcare providers to access your electronic health information. This information is shared through secure, electronic means and allows such 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 your treating provider(s) through Epic Care Everywhere. If you opt out, you also have a right to opt back in at any time by completing this form.

Patient Information (All sections required – please print clearly.)

Name (last, first, middle initial): ______________________ Date of Birth: ____________

Street Address: ______________________ City: ______________ State: _______ Zip: _________

Phone Number: ______________________ Email Address: ______________________

☐ **Request to Opt – Out** – I request that my health information be excluded from Epic Care Everywhere.

- I understand this means that other 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 also understand that in cases of medical emergency, my provider may request to view my health information to diagnose or treat my emergency medical condition and UI Health will make my records available through Epic Care Everywhere under such circumstances.

☐ **Request to Cancel (Rescind) Opt – Out** – 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 healthcare providers through Epic Care Everywhere, as permitted or required by UI Health or Federal/State law.

Please submit the completed and signed form:

- By mail: UI Hospital – HIM Department/Privacy Office, 833 South Wood Street, Suite B-52, Chicago, IL 60612, MC 772
- By fax: 312-413-8014
- By e-mail: privacyoffice@uic.edu

Please allow up to two (2) business days after receipt for processing the form. For questions, please call 312-355-5650 during business hours (Monday to Friday, 9:00 am – 5:00 pm).

______________________________________/______________________

Signature of Patient or Personal Representative **Date/Time** *(Required)*

____

Relationship to patient if signed by other than patient

______________________________________/______________________

Witness Signature **Date/Time** *(Required)*

UI HEALTH STAFF ONLY:

Date Received: ______________________

Processed By: ______________________

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