



**HEALTH INFORMATION EXCHANGE/
COMMONWELL OPT IN/OUT FORM**

This is the “Opt In/Out Form.” If you opt in, your healthcare providers will be able to access your health information through the Health Information Exchange or CommonWell, even in an emergency. If you opt out, your healthcare providers will not be able to access your health information through the Health Information Exchange or CommonWell, even in an emergency. If you are the legally authorized representative and are filling out this form for that person, the reference to “you”, “I” and “my” in this form refer to the person for whom you are authorized to consent.

- Option 1 – Participate in the Health Information Exchange and CommonWell:** I wish to share my information with the Health Information Exchange and CommonWell.
- Option 2 – I do not wish to participate in the Health Information Exchange and Commonwell:** I do not want any Banner information visible in the Health Information Exchange and Commonwell effective with today’s visit and forward. (Unless I elect option 1 at a later date.)

Patient/Authorized Representative

Relationship

Witness ID Number

Date/Time

2nd Witness Signature (if needed)

If signed by a person other than the patient, please indicate your authority to sign for the patient (check one):

- Spouse
- Parent/Guardian
- Legally Authorized Rep

If you are signing on behalf of more than one patient (such as your children), you must fill out a separate form for each patient.

Provider Office Only: Please complete before sending via secure fax or secure email to the Health Information Exchange/CommonWell.

Print Name: _____

Date/Time: _____

Signature: _____

