# Health Information Exchange Form: Opt-Back In Request

This form is for patients of Thundermist Health Center who previously chose not to participate in the Health Information Exchange (HIE) and now want to rejoin the program. This is called "opting back in." Please read the information below carefully before filling out and submitting the form.

A **Health Information Exchange (HIE)** is a secure online system that allows healthcare providers—such as doctors, hospitals, and labs—to share your health information. This system helps your healthcare providers stay updated on your medical history, which improves care and decision making. To learn more about the HIE program in Rhode Island, visit https://health.ri.gov/projects/healthinformationexchange.

Thundermist shares and receives your health information with other providers through the HIE, following strict privacy and security rules to keep your data safe. If you opted out before, your health information was not shared electronically with other providers. By opting back in, you allow your health information to be shared securely again, which helps improve how your care is coordinated. Please keep in mind that changes to your consent cannot be made in our system without written documentation signed by you or your authorized representative.

**How to Opt Back In**

To rejoin the HIE program, complete this form and check the box labeled "Opt Back In." You can submit the form using any of these options:

- **Drop it off** at any Thundermist Health Center location.
- **Email** it to: medicalrecords@thundermisthealth.org
- **Mail** it to: Thundermist Health Center
  25 John A. Cummings Way
  Woonsocket, RI 02895 Attn:
  Medical Records Dept.
- **Fax** it to: 401-235-6896

Once received, your request will be processed within **five business days**.

**Patient Information**
Please fill out the following details:

| | |
|---|---|
| **Full Name** | |
| **Date of Birth (mm/dd/yyyy)** | |
| **Address** | |
| **Phone Number** | |
| **Email Address (optional)** | |

☐ **Opt Back In**: I previously chose not to share my health information through the HIE, which meant my health information was not electronically available to other participants. By opting back in, I agree to let my health information be shared securely through the HIE. I understand this decision will allow my healthcare providers to access my health information, improving my care coordination and quality.

**Signature**
By signing below, I confirm that I have made an informed decision about rejoining the HIE program.

| | |
|---|---|
| Patient/Authorized Representative Signature | |
| If Authorized Representative, Relationship to Patient | |
| Date | |

**FRONT DESK/DOCT MGNT STAFF USE ONLY**

Processed by_____
*STAFF NAME (PRINT CLEARLY)*

Date Processed_____