Health Information Exchange Form Opt-Out Request

This form is for patients of Thundermist Health Center who do not wish for Thundermist to share and receive their health information through the Health Information Exchange (HIE), also called "opting out."

A **Health Information Exchange** is a secure online system that allows providers—such as physicians, pharmacists, 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 Health Center 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 choose to opt out, your health information will no longer be shared electronically. However, keep in mind:

- Your information may still be shared in emergencies, with public health authorities, with health plans for managing care, for quality reporting, or if required by law.
- Healthcare providers can still access your information using non-electronic methods like fax or mail.
- Changes to your consent cannot be made in our system without written documentation signed by you or your authorized representative.

How to Opt Out

If you want to opt out, fill out this form and check the "Opt Out" box. Submit the form using one of these methods:

- 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 Out:** I request that Thundermist Health Center stop sharing and receiving my health information through the HIE. I understand my information from past, present, and future will not be shared with healthcare providers and HIE participants, except as required by law.

Signature

By signing below, I confirm that I understand my choice to opt out of the HIE.

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_____