

## Patient Opt Back In To Certain Uses and Disclosures Form

Place patient label here or fill out information below:

Patient Name: \_\_\_\_\_

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

MRN: \_\_\_\_\_

As a patient, you have the right to request that Henry Ford Health System (HFHS) opt you back in of certain uses & disclosures of your patient information that you have in the past chosen to opt out of. Please check the use and disclosure (s) that you are requesting to **Opt Back In** to below and complete the coordinating section.

- Care Everywhere** (Section A)
- Health Information Exchange (HIE)** (Section B)
- Operational Use** (Section C)

When completed, please return this form to: Henry Ford Health System, ATTN: Information Privacy & Security Office, One Ford Place, Suite 2A, Detroit, MI 48202, or by Fax: (313) 874-9449, or email to [IPSO@hfhs.org](mailto:IPSO@hfhs.org). If you choose to email this form, please be aware that email is not encrypted and your information could be viewed while in electronic transit.

This form **must** be signed and dated; incomplete forms will be returned to you unprocessed. You will be notified in writing when your request has been processed. If you choose to "Opt Back Out", please contact the Information Privacy & Security Office using the contact information above.

### REQUESTER INFORMATION

If the requestor is the personal representative, please attach certifying documentation of your status as the personal representative, such as a Durable Medical Power of Attorney or Guardianship papers. The documentation will be scanned into the patient's medical record.

**Patient** \_\_\_\_\_  
(Name of Patient) (Date of Birth)

**Requested by (if other than patient):** \_\_\_\_\_  
(Personal Representative of Patient) (Relationship to Patient)

**Requestor Contact Information:** \_\_\_\_\_  
(Street Address) (City/State/Zip) (Telephone)

**Patient/Requestor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### SECTION A – OPT BACK IN TO CARE EVERYWHERE

Care Everywhere allows Henry Ford Health System (HFHS) to share your patient information electronically for continuity of your care. This provides other treating physicians real-time access to your patient information — without having to wait for your information to be transferred from one facility to another. You have the right to "opt-back in" to Care Everywhere by checking the box below:

- I hereby request that my Henry Ford Health System (HFHS) patient information be shared via Care Everywhere. I understand that this request only applies to the sharing of my HFHS medical record with other treating physicians who can receive data electronically.

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### SECTION B – OPT BACK IN TO HEALTH INFORMATION

HIE allows Henry Ford Health System (HFHS) to share your patient information electronically for continuity of your care. This provides other treating physicians real-time access to your patient information —without having to wait for your information to be transferred from one facility to another. You have the right to "opt-back in" to the Health Information Exchange by checking the box below:

- I hereby request that my Henry Ford Health System (HFHS) patient information be shared via the Health Information Exchange. I understand that this request only applies to the sharing of my HFHS medical record with other treating physicians who can receive data electronically.

### SECTION C – OPT BACK IN TO OPERATIONAL USE

HFHS may use certain patient information to perform operational activities without your authorization. You have the right to "opt-back in" to these operational activities by checking the appropriate box(es) below:

- I hereby request that my patient information be used for *marketing* campaigns and communications.
- I hereby request that my patient information be used for *fundraising* campaigns and communications.
- I hereby request that my patient information be used for *Satisfaction Surveys* and communications.
- I hereby request that my patient information be used to contact me for participation in *Research Studies*.

### FOR HFHS USE ONLY

For IPSO Use Only

Received By: \_\_\_\_\_ Date Received: \_\_\_\_\_ Date forwarded to Medical Records: \_\_\_\_\_  
(initials)

For HIM Use Only

Date scanned/Inserted into medical record or file: \_\_\_\_\_

Comments \_\_\_\_\_