



CARE EVERYWHERE® OPT OUT/OPT IN REQUEST FORM
Care Everywhere is a trademark of Epic Systems Corporation.

Patient Name:

DOB:

Or attach a patient label

Care Everywhere (CE) is a Health Information Exchange (HIE) system designed to allow participating healthcare organizations to electronically share patient medical records for the purpose of enhancing patient care, improving care coordination, and supporting clinical decision-making. While Care Everywhere provides significant benefits for both patients and healthcare providers, individuals retain the right to request that their health information not be shared through this network. Please refer to Legacy's [Notice of Privacy Practice](#) (NPP) for information on use of protected health information (PHI).

Most of your Legacy Health and our Connect Partners, information is automatically included in *Care Everywhere* unless you request in writing for it to be excluded. To have your Legacy Health and our Connect Partners, information excluded from *Care Everywhere* you must fill out and sign this Opt Out form. Examples of information that is NOT available via Care Everywhere includes substance abuse treatment, sexual assault/forensic records, and behavioral health treatment records. If, in the future, you want to change your Opt Out decision, you must complete a new form and send it to Legacy Health, Health Information Management (HIM) Department (Medical Records). Your request will be processed within ten business days of receipt.

Submission Instructions

- Please read all information provided prior to completing the form.
- Completed CE Opt Out/ In forms (pages 1 and 2) and supporting documentation as applicable can be submitted to Legacy Health by mail, or by secure email/fax where available.
 - Mail: Legacy Health ROI/HIE, P.O. Box 2868, Portland, OR 97208
 - Secure email: HIErequest@lhs.org
 - Fax: 503-225-8859
 - You can also leave your completed form with your providers office who will forward it to the appropriate department.
- If you need assistance or have questions about this form or the opt out process, please contact your Legacy Health provider's office.

Notice Regarding Privacy: Your privacy and the security of your health information are of utmost importance. For more information about your rights or the privacy practices of your healthcare provider, **please request a copy of the Notice of Privacy Practices.**

Reason for Opt Out (Optional) You may provide a reason for your decision to opt out of Care Everywhere. The information is optional and will be used to improve our understanding of patient preferences.

If you choose to use this section, please add your name and date of birth in the upper right corner space provided.
Reason for Opt Out (Optional):



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PLEASE PRINT PATIENT INFORMATION

Complete this form fully and legibly to avoid delays in processing.

Legal (or affirmed) First Name	MI	Legal (or affirmed) Last Name
Date of Birth (mm/dd/yyyy)		Daytime Phone
Mailing Address		Email Address

Please select either **Opt Out** or **Reverse my Opt Out** by checking one box below.

- ☐ I would like to **Opt out** of Legacy Health's Care Everywhere (CE) Health Information Exchange, or
- ☐ I would like to **Reverse my Opt Out** of Legacy Health's Care Everywhere Health Information Exchange.

Additionally, if you have selected to Opt Out of Care Everywhere the following statements must be read and acknowledged by initialing each line:

- _____ **Initials** - I understand that by opting out of Care Everywhere, my health information will not be electronically shared by my healthcare provider with other healthcare providers or organizations participating in Care Everywhere, except as required by law.
- _____ **Initials** - I acknowledge that this opt out applies only to electronic exchange through Care Everywhere and does not affect other permitted uses or disclosures of my health information under federal and state law.
- _____ **Initials** - I recognize that opting out may result in delays in care or limited access to my medical information by other providers in emergency or routine healthcare situations.
- _____ **Initials** - I understand that I may revoke or change this opt out status at any time by submitting a written request to my healthcare provider's Health Information Management department.
- _____ **Initials** - I understand any records previously transmitted from Legacy Health's instance of Epic in Care Everywhere to another institution will still be visible to other providers outside of Legacy. The Care Everywhere opt out will only stop subsequent health information exchange from the date the request is processed. It will not remove or delete health information already shared.

Additional Information

This opt out is specific to Care Everywhere and does not apply to other health information exchange platforms or mechanisms. Your healthcare provider will continue to use and disclose your health information as permitted or required by applicable laws and regulations.

Signature

Patient/Authorized Representative Signature: _____ Date: _____

If Authorized Representative, Relationship to Patient: _____

Print Representative Name: _____

For Office Use Only

Date Received: _____

Processed By: _____

Date Opt Out/In Effective: _____

FREQUENTLY ASKED QUESTIONS & ANSWERS

What is Care Everywhere? Care Everywhere is a health information exchange system designed to allow participating healthcare organizations to electronically share patient medical records for the purpose of enhancing patient care, improving care coordination, and supporting clinical decision-making. While Care Everywhere provides significant benefits for both patients and healthcare providers, individuals retain the right to request that their health information not be shared through this network. This form enables you to formally opt out of Care Everywhere, meaning your health information will not be electronically exchanged with organizations outside of Legacy Health's instance of Epic through this system except as required by law. Please read the following information carefully before submitting your request.

What type of information is shared/available? Patient health information includes most of the information in the electronic health record. There are some very specific types of information, though, that are NOT shared this way.

What type of information is NOT shared/available through Care Everywhere? Information that will not be shared through Care Everywhere includes behavioral health treatment, substance use disorder program services, and sexual abuse/forensic records.

What happens when I opt out of Care Everywhere? Your health data will not be shared electronically with external organizations through Care Everywhere. Providers within the same organization may still access your records for treatment, payment, and healthcare operations as permitted by law. However, in certain circumstances, such as public health reporting, legal mandates, or emergencies, some information may be shared regardless of your opt out status as required by law.

Can I change my mind? Yes. You may revoke or modify your opt out status at any time by submitting a completed *CARE EVERYWHERE® OPT OUT/OPT IN REQUEST FORM* to Legacy's Health Information Management department.

Who can see my information in Care Everywhere? Only health care professionals involved in your care during your health care visit can view your information. Healthcare professionals may only access your information to coordinate your care and treatment.

Will opting out affect my care? Opting out may affect care coordination and information availability in emergencies or when receiving care from providers outside your primary healthcare organization.

How long does it take for my change in preference for Care Everywhere to take effect? Updating your Care Everywhere option ***may take up to ten business days.***

If I opt out of Care Everywhere, does that mean that other health care providers cannot obtain my health information without my written consent? No, state and federal laws still allow access to most of your health information, without your written consent, if the request is made by other health care providers who are involved in your care. This information would be shared via telephone, mail, or electronically.

How can I help provide the fastest approval time? To ensure the fastest approval time, please complete all fields, including your name, address, phone number, valid email, and signature. Return to Legacy as noted on page one (1) in ***Submission Instructions.***