Health Information Exchange
Opt-Out Form

This form is for patients who do not wish to participate in the electronic health information exchange, known as Central Coast Health Connect (CCHC).

A health information exchange (HIE) is a way of sharing your health information among participating doctors' offices, hospitals, labs, radiology centers, and other healthcare providers through secure, electronic means. This gives participating caregivers the most recent information available from your other caregivers when they are making decisions about your care. If you opt out of participating in CCHC, your doctor and other care providers will still be able to use the system to have your lab results, radiology reports, and other data sent to them; previously, they may have received this information by fax, mail, or other electronic communication. **Choosing to opt out only restricts the sharing of information between providers.** When applicable, in accordance with laws, the required reporting of infectious diseases to public health officials will also occur through the HIE, even if you opt out.

To opt out of the HIE complete this form; it is not necessary to complete a form for each provider. If you do not live in Monterey County, but still receive care in Monterey County, you should complete this form to opt out. If you wish to reverse your decision, you may opt back in at any time by calling (831) 644-7494. Please note: Opt-out requests will be processed within (5) business days.

Mail signed and completed form to: CCHC Help Desk, 10 Ragsdale Drive, Suite 102, Monterey, CA 93940
Or scan and e-mail signed form to cchc-help@centralcoasthealthconnect.org or fax to (831) 644-7451.

INFORMATION OF PATIENT OPTING OUT (please print clearly)

Patient name ____
FIRST MIDDLE LAST

Address ____

____

City ____________________ State __________ Zip code ____________

Primary phone number (   ) ____________________ Secondary phone number (   ) ____________________

E-mail address ____

Date of birth ____________________ Sex: ☐ *Male* ☐ *Female*

Reason for opting out (optional) ____

____

____

If this form is signed by someone other than the person above, the person signing the form hereby certifies that he/she is acting as:

☐ *Parent* ☐ *Legal guardian* ☐ *Other* (specify relationship)

Contact information for individual completing this form if other than patient

Printed name ________________________________ Phone number (   ) ____________________

Patient Information

Printed name ________________________________

Signature ________________________________ Date ____________________