Wellstar Health System
Care Everywhere Opt Out Request

Wellstar Health System, Inc. participates in a Health Information Exchange (HIE) through Epic Care Everywhere that allows other healthcare organizations and providers to access your electronic health information. This information is shared through secure electronic means and allows other healthcare organizations and providers to have the most recent available information to care for you as a patient.

You may opt out if you do not want your health information to be shared with your treating provider(s) through Epic Care Everywhere. If you opt out, you also have a right to opt back in at any time by completing this form.

Patient Information (all sections required - please print clearly):

Name (please print): _____ Date of Birth: _____

Street Address: _____ City: _____ State: _____ ZIP: _____

Phone Number: _____ Email Address: _____

r **Request to Opt Out** - I request that my health information be excluded from Epic Care Everywhere.

- I understand this means that other healthcare providers will not be able to obtain my health information through Epic Care Everywhere. My healthcare providers can still obtain my medical records through other methods.
- I understand that any information that was shared through Care Everywhere previously will remain available to providers who have access.
- I also understand that in cases of medical emergency, my provider may request to view my health information to diagnose or treat my emergency medical condition and Wellstar Health System will make my records available through Epic Care Everywhere under such circumstances.

r **Request to Cancel (Rescind) Opt Out** - I request to cancel my previous decision to opt out. By completing and signing this form, I am allowing my health information to be shared with my healthcare providers through Epic Care Everywhere, as permitted or required by Wellstar Health System or Federal / State law.

_____ (or) _____
Print Patient Name — Print Name of Legal Guardian / Authorized Personal Representative

_____ (or) _____
Signature of Patient — Signature of Legal Guardian/Authorized Personal Representative*
*Please indicate your relationship to the patient:

_____ _____
Date of Patient Request

Please Return to the Following Postal or Email Address:

Wellstar Health System, Attn: Chief Privacy Officer
793 Sawyer Road, Marietta, GA 30062
470-644-0444 email: privacyofficer@wellstar.org

TO BE COMPLETED BY WELLSTAR STAFF ONLY

Date Received: _____

Processed By: _____

Wellstar

r AMC r Kennestone r Sylvan Grove
r AMC South r North Fulton r West Georgia
r Cobb r Paulding r Windy Hill
r Douglas r Spalding r _____

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