CalMHSA Connex Health Information Exchange Patient Opt-out Form

☐ **Opt-Out**

My information may not be accessed through the CALMHSA CONNEX HIE.

Please note that opting out of the CALMHSA CONNEX HIE will only prevent your data from being accessed via the CALMHSA CONNEX HIE system.* ***Opting out of the CALMHSA CONNEX HIE does not prevent your caregivers from sharing your information.* *If you wish to completely halt the sharing of your information electronically, you must reach out to each organization/provider(s) and request to do so.*

☐ **Cancel Opt-Out**

I request you to cancel my previous decision to opt-out. By completing and signing this forum, I am allowing my health information to be accessible to my health care providers through the CALMHSA CONNEX HIE, as permitted or required by Federal or State law.

All fields must be filled out to process your opt-out request.

First Name, Middle Initial, Last Name

**If you are a legal representative/authorized individual, please add your name after the patient's name with your relation to the patient.*

Street Address

City, State Zip Code

Birth Date (MM/DD/YY) Gender (M, F, Other) Last 4 Digits of Social Security Number

Client/Patient Signature or Legal Representative* Date (MM/DD/YY)

**By signing as a legal representative, I am certifying that I am legally authorized to act on behalf of the patient.*
Identification verification will be required for both patient and/or legal representative/authorized individual to complete the request.