Yale Medicine | Yale NewHaven Health

CARE EVERYWHERE® OPT-OUT REQUEST

Federal and state laws allow healthcare organizations to disclose much of your health information, without your written permission for treatment, payment, or healthcare operations related purposes. This information may be disclosed to external healthcare organizations or healthcare professionals with whom you have an established treatment relationship. These organizations and individuals may request your health information electronically, for continuity of your care, from Yale New Haven Health (YNHH) and/or Yale Medicine (YM) (collectively "we" or "our"), as well as any organization that licenses use of our medical record. The electronic sharing of your health information for these treatment purposes is helpful for relaying information in a secure and efficient manner without delays.

Our organizations utilize an electronic sharing module within the medical record called Care Everywhere, which is available to all healthcare organizations who utilize the Epic electronic medical record system. Most of your health information is automatically included in Care Everywhere unless you request for it to be excluded. There may be certain records that are not included in Care Everywhere due to additional restriction requirements.

To opt out and have your health information excluded from Care Everywhere, please complete this form and submit via one of the following methods outlined below. You may change this decision at any time.

Patient First Name	**Patient MI**	**Patient Last Name**
Date of Birth (MM/DD/YYYY)		**Phone Number**

☐ **Opt-out:** I request that my medical information be excluded from Care Everywhere.

- I understand that by opting out of Care Everywhere other healthcare organizations and healthcare professionals will not be able to obtain my health information electronically through Care Everywhere, except to the extent action has already been taken to release information prior to receipt of this opt-out request.
- I understand that healthcare professionals treating me can still obtain this treatment information by other means, such as placing a request with the Health Information Management department or medical records department for copies of my records.
- I understand that YNHH and/or YM cannot 'block' access to my medical record by healthcare professionals or individuals who utilize our electronic medical record.
- I understand that this opt-out request is voluntary and my treatment at this organization is in no way conditioned on whether I sign this form.
- I understand that this opt out request only applies to information created by Yale New Haven Health and/or Yale Medicine; if; I would like to opt out of Care Everywhere at another external medical facility that utilizes the Epic medical record, I must contact that organization's privacy office.

☐ **Reverse my Previous Opt-out:** I previously chose to opt-out of Care Everywhere and the electronic sharing of my health information with external healthcare organizations and professionals. I am now choosing to participate (Opt-In) and allow my information to be shared via Care Everywhere to external healthcare organizations. By checking this box and signing this form, I am reversing my prior request to exclude my health information from Care Everywhere.

_____ _____

Signature of Patient or Authorized Representative** **Date**

If not patient, please indicate relationship:

_____

***Must provide proof of legal authority (except parent of a minor)*

Please submit this form to:

For Yale New Haven Health Requests:
Email: Privacy@ynhh.org
Mail: Attn: Office of Privacy and Corporate Compliance
300 George Street, 4th Floor
New Haven, CT 06511
Phone: 203-688-8416

For Yale Medicine Requests:
Email: HIPAA@yale.edu
Attn: HIPAA Office
P.O. Box 208255
New Haven, CT 06520
Phone: 203-432-5919

Interpretation Services (if necessary): An interpreter facilitated the communication between the health care provider(s) and the patient or authorized patient representative in _____ (language) to assist in obtaining informed consent or sharing/acknowledging information.

The interpreter conveyed the content of the original information expressed by and for both parties.

Time: _____ AM/PM Date: _____

Check here if: ☐ Telephone ☐ Video ☐ In person ☐ Bilingual Competency Program Approved Staff

ID Number (telephone/video only): _____

_____ Print Name of Interpreter

_____ Signature of **Interpreter (in-person only)**

YHS000515_English (N 01/23)
Available in multiple languages