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	Kennedy University Hospi ☐ Cherry Hill ☐ Stratford ☐ Wa		Name:				
	☐ Cherry Hill ☐ Stratford ☐ Washington Twp. KENNEDYCONNECT HEALTH INFORMATION EXCHANGE OPT-OUT		Date of Birth:/				
			City:	State:		Zip:	
			Phone:		e-mail:		
Ιh	ereby <u>acknowledge</u> and <u>agree</u> as follows	:					
1.	I WISH to OPT-OUT of the KennedyConnect HIE . I understand that by making this selection, NONE of my health care providers will be able to access my clinical health information maintained anywhere on the KennedyConnect HIE, even in cases of a medical emergency;						
2.	UNDERSTAND that my providers who originally generated information about me will continue to have access to my information, but only in the medical record that <u>they</u> created for me, or by obtaining it via previously established methods;						
3.	UNDERSTAND that this HIE Opt-Out will not allow Kennedy Health System to make my clinical health information available to other Connected HIEs with whom Kennedy Health System participates, even in cases of a medical emergency.						
4.	understand that this HIE Opt-Out does NOT cover or effectuate my opting-out of any other HIE. I understand that if vish to opt-out of another HIE, I am responsible for approaching my provider participating in such other HIE about how can do that;						
5.	My HIE Opt-Out selection will remain in effect unless I change it in writing;						
6.	I UNDERSTAND that once this Opt-Out goes into effect, I can change my mind only by submitting a <u>Revocation of Prior Opt-Out</u> form;						
7.	I have had an opportunity to have all my questions about this "HIE Opt-Out" and any others answered;						
8.	Any information that is disclosed before I submit this HIE Opt-Out cannot be taken back, and will remain with my provider who may have accessed such information before this Opt-Out went into effect; and						
9.	This request can take 2 business days	nis request can take 2 business days to take effect.					
Siç	gnature:	Date:	_				
If L	egal Rep, state Authority:						

Completed and signed KennedyConnect HIE Opt-Out form can be returned to any Healthcare Access Desk; faxed to (856)661-5262; or mailed to:

Kennedy Health System – Information Systems & Technology KennedyConnect HIE 500 Marlboro Avenue Cherry Hill , NJ 08002