HealthShare Exchange

190 N. Independence Mall West | Suite 701 | Philadelphia PA 19106 | 215.391.4905 | www.healthshareexchange.org

HealthShare Exchange (HSX) Patient **Opt-Back-In Form**

Consumers who have previously requested that their healthcare information NOT be included in the health information exchange (HIE) activities of HealthShare Exchange (HSX), the HIE organization for the Greater Philadelphia and Delaware Valley areas, including southeastern Pennsylvania and southern New Jersey, may use this to opt back in to participation with HSX.

In HIE, participating healthcare providers exchange patient health and healthcare information, in a secure and confidential way, for purposes of providing care to patients. The health information of individual who submit this Opt-Back-In Form will be made accessible again to healthcare providers and other authorized users through the HSX.

This form supersedes any previously submitted Opt-Out Forms to HSX. Therefore, HSX participants who search for information on the individual submitting this form will receive healthcare information upon request.

Individuals who have opted back in can choose to opt back out of the HIE again at any time by using the Opt-Out Form at
https://www.healthshareexchange.org/patient-options-opt-out-back
or by calling (855) 479-7372 (HSX-SEPA) or emailing consent@healthshareexchange.org.

Submission of Opt-Back-In Form

The HSX Opt-Back-In Form can be completed online at:
https://www.healthshareexchange.org/patient-options-opt-out-back
In addition, HSX will accept either the HSX Opt-Back-In Form or the PA Patient and Provider Network OPT-OUT or OPT-BACK-IN FORM by email to consent@healthshareexchange.org, or by fax submission to 215-422-4333, or through postal mail to:

HealthShare Exchange
American College of Physicians Building
190 N. Independence Mall West, Suite 701
Philadelphia, PA 19106
attention: Consent Management Department

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To opt out, please fill out the information below and submit this form:

Patient Information

First Name*	______________________
Middle Name	______________________
Last Name*	______________________
Maiden Name (If Applicable)	______________________
Current Address*	______________________
Current City*	______________________
Current State*	______________________
Current Zip Code*	______________________
Current Country*	______________________
Primary Phone Number*	______________________
Secondary Phone Number	______________________
Current Email Address	______________________
Date of Birth* (mm/dd/yyyy)	______________________
Gender*	______________________
Social Security Number or Last Four Digits	______________________

* Required Information

Parent or Guardian Information (if applicable)

First Name	______________________
Last Name	______________________
Primary Phone Number	______________________
Current Email Address	______________________
Relationship	______________________

Submitter's statement: In completing this Opt-Out Form, I verify that I am the person named above, or I am legally authorized to complete this form for the person named above. The information provided on this form, and the preferences expressed herein, are accurate to the best of my abilities. Date: ______________________

Notification of Opt-Back-In

Person's submitting this Opt-Back-In Form, have the right to be notified that their opt out has been completed. Please indicate preferred method of notification:

phone

letter

no notification