SaintFrancis Health System

Care Everywhere Access Network Opt Out/Opt Back In Request Form

Complete this form in front of and submit to your healthcare provider, who must sign below.

Care Everywhere is a tool within your healthcare provider's electronic medical record used to securely share your patient record with other healthcare providers. By initialing the appropriate box below, you indicate that you have read, understand and agree to the following action:

☐ I request to **OPT OUT of Care Everywhere** and understand that by initialing this box and submitting this form, my health information will not be viewable by healthcare providers through Care Everywhere except in emergency situations. I understand that I am free to opt back in at any time.

☐ I request to **OPT BACK IN to Care Everywhere** and understand that by initialing this box and submitting this form, my health informaton will be viewable by all healthcare providers through Care Everywhere.

I understand this request only applies to sharing my health information through the Care Everwhere system. I recognize that when I see a health care provider for treatment, that provider may request and receive my medical information from other providers using other methods permitted by law, such as fax, mail, secure messaging, or other means.

(A separate request form must be filled out for each family member. All fields are required for form to be processed. A contact phone number is required in case Care Everywhere needs to contact you to ensure accuracy of demographic information.)

Patient First Name:	**Patient Middle Name:**	**Patient Last Name:**
Previous Names or Nicknames:		**Date of Birth (mm / dd / yyyy):**
Mailing Address:		**Last 4 digits of Social Security Number:**
City, State, Zip Code:		
Contact Phone Number:		

For your protection, CARE EVERYWHERE REQUIRES THAT YOU VERIFY YOUR IDENTITY to process this Request.

_____ _____

Signature of Patient (or Authorized Representative)
If under 18 years, signature of parent or guardian

Date Signed

_____ _____

Organization Rep Signature as Witness

Position and Name of Organization

Notary Public Section

If you cannot complete this in person with your healthcare provider, you may have this form notatrized and fax to 918-494-6222.

State of_____ County of _____

The foregoing instrument was acknowledged before me this _____ by_____.
(Date) (Name of person acknowledged)

Notary Print Name: _____

Notary Signature: _____

Notary Stamp