DEPARTMENT OF HEALTH SERVICES **STATE OF WISCONSIN**
Division of Care and Treatment Services
F-03276 (03/2024)

Health Information Exchange Patient Choice

Complete and submit this form if:

- You choose **not** to allow your health information to be exchanged (you choose to opt out).

or

- You previously had chosen to opt out but would like to change that decision and opt back in so your health care providers can securely access your health information.

You decide if you want your health care providers to have timely and secure access to your health information electronically. Participation is automatic. However, you can choose **not** to participate. This is called opting out. If you opt out, your health care providers will not be able to access your health information to use while treating you, except in cases of an emergency, for public health reporting as permitted by law, and for your medication list.

If you opt out, you accept the risks associated with denying your health care providers access to your health information.

Full Name (First/Middle/Last)

Date of Birth (Month/Date/Year)	Patient Identifying Number

☐ **Opt Back In**: I wish to terminate my previous request to opt out of having my essential health information shared electronically. My health information will be available to my health care providers.

☐ **Opt Out**: I wish to **opt out** of having my essential health information shared electronically with my doctors.
Note: This only affects future information sharing. Any information shared prior to this form being submitted will not be affected. Submitting this form allows changes to WISHIN and Commonwell Health Information Exchange access in the electronic health records system used by the Wisconsin Department of Health Services.

Reason for Request

Opt-Back In Certification

Please initial here: _____
I certify that I understand opting in will allow health care providers access to my health information.

Opt-Out Certification

Please initial here: _____
I certify that I understand opting out will prevent health care providers from access to my health information.

Signature of Patient	Date
Staff Witness Signature	Date

To opt back in or to opt out, you must complete and submit this form to the health records office of the Wisconsin Department of Health Services facility that treated you. It may take up to three business days to process your request. You will be contacted after your request is processed.

Reset