Health eNet Community Health Record - Request to Stop Individual Participation

Your health information is viewable electronically through the Hawai'i Health Information Exchange Health eNet Community Health Record (CHR). Health care providers who have a relationship with you may search Health eNet for your health information to provide you with coordinated and comprehensive health care. You have the option to request that your health information not be viewable through the Health eNet CHR. This is called 'Opt-Out'. Your health information will not be searchable or viewable during the time you are Opted-Out. You may opt back in at any time. Please talk to your health care provider if you have any questions.

I request that my health information NOT be viewable through the Hawai'i HIE Health eNet CHR.
Please initial that you have read and understand the following statements:

____ I understand that once this Request to Stop Individual Participation has been processed, my health information may still be contributed to the Health eNet CHR, but will not be viewable by healthcare providers (including emergency room physicians) through Health eNet CHR.

____ I understand that my health care providers can still exchange my health information for treating me using other methods as permitted by law, including fax and/or mail or other Health eNet information exchange services.

____ I understand that I am free to opt back in at any time by completing a Request to Resume Individual Participation from www.hawaiihie.org. I further understand that my health information contributed to the Health eNet CHR, but not accessible during the opt-out period, may be viewable in the Health eNet CHR once I opt back in.

To Opt-Out, please complete the required information below and submit this form to your health care provider. Your request will be processed within ten (10) business days from receipt by the Hawai'i HIE. You will receive a letter from the Hawai'i HIE confirming receipt of this request. * = *required information*

Patient First Name *	Patient Middle Name	Patient Last Name *	
Patient Nickname/Previous Name(s)	Patient Gender (M/F) *	Patient Date of Birth (mm/dd/yyyy) *	Last 4 of Patient SSN *
Patient Address *	City *	State *	Zip *
Patient Primary Phone # *	Patient Secondary Phone #	Patient Email Address	
Signature of Patient *		Date Signed *	
Signature of Legal Authorized Representative * (on behalf of patient)		Relationship / Legal Authority to Individual *	
To grant this request, a health care provider that has an established treatment relationship with you must complete the boxes to the right, and mail or fax this form to the Hawai'i HIE. We do NOT accept requests directly from patients or their authorized representatives.			
Health Care Provider Granting Request *		Name and Title of Staff Member Submitting Request *	

Please mail or fax this form to:

Hawai'i HIE
Attn: Community Relations
900 Fort Street Mall, Suite 1305
Honolulu, Hawai'i 96813
Fax: (808) 441-1472

You may also contact us for more information at: (808) 441-1374

For Hawai'i HIE staff only:

	Option to opt-out status changed		Form scanned/filed		Letter mailed, date: