HIE Change Request

Southeast Coalition on Health (Network), a Health Information Exchange (HIE), assists health care providers and other health care entities provide or receive information from each other related to your care through secure, electronic means. Having access to up-to-date and complete information can improve the speed, quality and safety of care. Information provided or received through the HIE is not a complete medical record of your health history. An HIE is not the only source where health care providers or other health care entities involved in your care may provide or receive your health information.

The purpose of this form is to permit you to request that Network restrict health care providers and other health care entities involved in your care from receiving your health information through the HIE.

Please initial that you have read and understand the following statement:

_____ I understand this HIE Change Request applies only to health care providers and other health care entities involved in my care that might receive health information about me through the HIE.

Select one action:

_____I request Network restrict health care providers or other health care entities involved in my care from receiving my health information through the HIE.

_____I terminate my previous request and authorize Network to allow health care providers or other health care entities involved in my care to receive my health information through the HIE.

Patient Legal First Name	Middle Name	Last name
Other names used (maiden name, nicknames, etc)		
Street Address		
City	State	Zip Code
Phone Number	Date of Birth (MM/DD/YYYY)	Last 4 digits of patient's Social Security Number

Parent / Guardian / Personal Representative Name	Relationship to Patient

_____ _____

Signature of Patient or Patient Representative Date

_____I request an email confirmation that this request was successfully delivered to Network.

Email

----------Section below to be completed by a Notary Public or Physician----------

State of_____ County of _____

The foregoing instrument was acknowledged before me this_____by_____.
(date) (name of person acknowledged)

Print Name: _____

Signature:_____
Physician or Notary

Notary Stamp if verified by Notary

Please mail this form to: SECOH
P.O. Box 2629
Calhoun, GA 30703