Camden Coalition Health Information Exchange Opt-Out Form

This form is to be used by patients who do not wish to participate in the Camden Coalition Health Information Exchange.

Instructions: Please fill out this form to opt out of the Camden Coalition Health Information Exchange. Once completed, please return the form to the Medical Records Department at the address below. Opt out requests may take up to two (2) business days from date of receipt to process.

Address:
Attention: Medical Records Department
Our Lady of Lourdes Hospital
1600 Haddon Avenue
Camden NJ 08103

Patient Information		
***First Name:**	***Last Name:**	
***Date of Birth** (mm/dd/yyyy):		
Contact Information		
***Street Address:**		
***City:**	***State:**	***Zip Code:**
***Primary Telephone Number:**	**Secondary Telephone Number:**	
Email Address:		
Reason for Deactivation (Optional)		
Please explain your reason for opting out.		
Authorization - I understand that by making this selection NONE of my providers will be able to electronically access any information about me through the Camden Coalition Health Information Exchange, even in cases of a medical emergency.		
***Signature**	***Date**	
If this form is signed by someone other than the patient named above, the person signing the form hereby certifies that he/she is acting as: (check one) ☐ Parent ☐ Legal Guardian ☐ Other (Specify Relationship _____ **for the patient named above.**		
Contact Information for Individual Completing This Form If Other Than Patient (Please print clearly)* Printed Name: Telephone Number:		

*required fields