

## Instructions for Completing: Cancellation of Opt-Out Request

Dear Patient:

You previously submitted a request to opt-out of the Carolinas HealthCare System CareConnect. We have since received a request from you letting us now you would like to begin participating again (Opt-In) in the Carolinas HealthCare System CareConnect Health Information Exchange.

By submitting a *Request for Cancellation of Opt-Out* form, your test results and medical information will be accessible to authorized health care providers through Carolinas HealthCare System CareConnect. This includes any test or other medical information that was generated while you were opted out. In order to begin participating in Carolinas HealthCare System CareConnect, please complete the attached *Request for Cancellation of Opt-Out* form.

### **Carolinas HealthCare System CareConnect can benefit you and your doctor**

The Carolinas HealthCare Information Exchange (Carolinas HealthCare System CareConnect) provides a secure and fast exchange of test results and other medical information to participating hospitals, labs, x-ray facilities and doctors who participate. Carolinas HealthCare System CareConnect is *not* a complete record of your health history. It is simply a way for health care providers that participate in this exchange to access the medical information they need to provide you with better care.

- Carolinas HealthCare System CareConnect is a **secure** way for your doctor to get the most up-to-date medical information about you. For example, information that could help save your life in a medical emergency will be available to emergency room (ER) doctors at participating hospitals. Only health care providers with a valid reason will be allowed to see your test results and other medical information.
- Carolinas HealthCare System CareConnect **improves care** by sending results to your doctor quickly and securely. Carolinas HealthCare System CareConnect also serves as a second storage area, so your results and records are safe in case of an emergency, such as a fire or flood.
- Carolinas HealthCare System CareConnect **protects privacy** by having safeguards in place to protect your information.

If you have any questions, please contact Carolinas HealthCare System CareConnect:

- Call Carolinas HealthCare System CareConnect: 888-724-0459
- Visit the Carolinas HealthCare System CareConnect website:  
[www.carolinashealthcareconnect.org](http://www.carolinashealthcareconnect.org)

*Thank you for choosing to participate in Carolinas HealthCare System CareConnect!*

# Request for Cancellation of Opt-Out Carolinas HealthCare System CareConnect

By signing and submitting this form you are indicating that you have read and understand the following conditions to which you are requesting to reinstate participation within the Carolinas HealthCare System CareConnect and the ability for healthcare providers to view your personal health records electronically.

- I had previously chosen not to participate in Carolinas HealthCare System CareConnect and completed a Request for Opt-Out Form.
- I understand that by submitting this form, my personal health information will now be viewable by providers within the Carolinas HealthCare System CareConnect, including emergency room physicians.
- I understand the information generated while I was opted out will be included in the information that will be viewable in the Carolinas HealthCare System CareConnect.
- I hereby authorize Carolinas HealthCare System CareConnect to cancel my request for Opt-Out of the Carolinas HealthCare System CareConnect.
- I am requesting to opt-in for myself or for those minor children (up to 18 years of age) of whom I am the parent or legal guardian.
- For your protection, Carolinas HealthCare System CareConnect requires you verify your request by completing the form and **signing it in blue or black ink.**

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Previous Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ (Ex: 01/01/1990) Gender:  Female  Male

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone 1: \_\_\_\_\_ Phone 2: \_\_\_\_\_

Email Address: \_\_\_\_\_ Last Four (4) Digits of Social Security Number: \_\_\_\_\_ (Ex. xxx-xx-1234)

Patient Signature:  X  \_\_\_\_\_ Date Signed: \_\_\_\_\_  
(If under age 18 years, signature of parent or legal guardian)

***This form must be returned to Carolinas HealthCare System CareConnect with original signatures in one of the following ways:***

**Fax To:** 704-446-2267

**Email To:** [info@carolinashealthcareconnect.org](mailto:info@carolinashealthcareconnect.org)

**Mail To:** Carolinas HealthCare System CareConnect, P.O. Box 32861, Charlotte, NC 28232