

**Care Everywhere Opt-In Request Form**

Name of patient (please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AHWFB Medical Record Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

You previously opted out of having your electronic protected health information made available to non- Atrium Health Wake Forest Baptist (AHWFB) hospitals, physicians, and health care providers through Care Everywhere. By signing and submitting this form, you are reversing your previous decision and agreeing that AHWFB may, going forward, electronically share your protected health information with non-AHWFB health care providers through Care Everywhere.

**Request to Permit Electronic Exchange of My Health Information through Care Everywhere.**

I would like my medical information to be available through Care Everywhere to non-AHWFB health care providers who are seeking this information to treat me. By signing this form, I am revoking my prior request to exclude my medical information from being electronically exchanged through Care Everywhere.

I understand that this revocation of my previous restriction will be effective upon receipt and processing by AHWFB, which may take up to 2 business days. If in the future I change my mind and wish to restrict my health information from being available or released through Care Everywhere, I understand that I must fill out the Care Everywhere Notice and Opt-Out Request Form, which is available on the AHWFB website or by contacting the AHWFB Health Information Management Department at 336-716-3230.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name/Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Return signed form to**: Atrium Health Wake Forest Baptist Health Information Management Department Medical Center Boulevard, Winston- Salem, NC 27157 by email [HIM\_HIPAA@wakehealth.edu](mailto:HIM_HIPAA@wakehealth.edu) or fax to 336-716-5386.