Kennedy University Hospital

☐ **Cherry Hill** ☐ **Stratford** ☐ **Washington Twp.**

KENNEDYCONNECT HEALTH INFORMATION EXCHANGE REVOCATION OF OPT-OUT

Name: _____

Date of Birth: ____/_____/_____

Street Address: _____

City: _____State: _____ Zip: _____

Phone: _____ e-mail: _____

I hereby acknowledge and agree as follows:

1. I WISH TO REVOKE (change) my prior decision to Opt-Out of the KennedyConnect HIE, and now **specifically AUTHORIZE** my information maintained in the KennedyConnect HIE to be electronically available to my providers;

2. I UNDERSTAND that by making this selection, now ALL of my authorized providers who participate in the KennedyConnect HIE or are connected to the KennedyConnect HIE will have access to my health information maintained in the KennedyConnect HIE;

3. I UNDERSTAND that by making this selection, my health information may be accessible by other Connected HIEs with whom the KennedyConnect HIE participates.

4. I UNDERSTAND that this Revocation can only be changed if I specifically submit a new HIE Opt-Out form;

5. I have had an opportunity to have all my questions regarding this "Revocation of Prior Opt-Out" and others answered; and

6. This request can take **2 business days** to take effect.

Signature: _____ Date:_____

If Legal Rep, state Authority: _____

Completed and signed KennedyConnect HIE Revocation of Prior Opt-Out form can be returned to any Healthcare Access Desk; faxed to (856)661-5262; or mailed to:

Kennedy Health System – Information Systems & Technology
KennedyConnect HIE
500 Marlboro Avenue
Cherry Hill , NJ 08002