Health Information Exchange Patient Opt-Out Form
This form is to be used by patients who do not wish to participate in the SandlotConnect Health Information Exchange (HIE).

A Health Information Exchange, or HIE is a way of sharing your health information among participating doctors’ offices, hospitals, labs, radiology centers, and other health care providers through secure, electronic means. The purpose is so that each of your participating caregivers can have the benefit of the most recent information available from your other participating caregivers when taking care of you. When you opt out of participation in the HIE, doctors and nurses will not be able to search for your health information through the HIE to use while treating you. Your physician or other treating providers will still be able to select the HIE as a way to receive your lab results, radiology reports, and other data sent directly to them that they may have previously received by fax, mail, or other electronic communications. Public Health reporting, in accordance with law such as the reporting of infectious diseases to public health officials, will also occur through the HIE after you decide to opt out.

This opt out form only needs to be completed once to opt out of the HIE; it is not necessary to complete for each provider. If you do not live in Texas but still receive care in Texas, you should complete this form to opt out. If you wish to reverse your decision you may opt back in at any time by completing an opt in form and mailing it to 6445 Harris Parkway, Suite 100, Fort Worth, TX 76132.

You have several options for opting out of the SandlotConnect Health Information Exchange. Please select one below.

2. Mail your completed form to GANT, 6445 Harris Parkway, Suite 100, Fort Worth, TX 76132, Attn: HIPAA Committee
3. Fax your completed form to 817-263-5849 Attn: HIPAA Committee

Information for Patient Opting Out (Please print clearly)

<table>
<thead>
<tr>
<th>First Name*</th>
<th>Middle</th>
<th>Last*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address*</td>
<td>City*</td>
<td>State*</td>
</tr>
<tr>
<td>Primary Phone Number*</td>
<td>Secondary Phone Number</td>
<td></td>
</tr>
</tbody>
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*Sex: M / F
Date of Birth*

I would like to be notified of my participation choice in the following way (contact information must be included on form): ___ Phone Call ___ Letter ___ Text ___ No Notification

*Required

Reason for Opting Out (optional):

If this form is signed by someone other than the person named above, the person signing the form hereby certifies that he/she is acting as: (Check One) ___Parent ___Legal Guardian ___Other (specify Relationship)_______________

Contact information for Individual Completing This form If Other Than Patient (Please Print Clearly)*

Printed Name__________________________________ Phone Number__________________________

Patient Information (Please Print Clearly)*

Printed Name__________________________________

Signature____________________________________ Date__________________________