

# UW Medicine Epic Care Everywhere Patient Opt-Out

UW Medicine participates in a Health Information Exchange (HIE) through Epic Care Everywhere that allows health organizations who utilize Epic as their electronic health records system to exchange electronic health information. This information is shared through secure, electronic means and allows such providers to have the most recent available information to care for you as a patient.

You may opt out if you do not want your health information to be shared with your treating provider(s) through Epic Care Everywhere. If you opt out, you also have a right to opt back in at any time by completing this form.

**NOTE: UW Medicine and Seattle Cancer Care Alliance share an Epic Medical Record. Opting out from either one will opt you out of both.**

**Patient Information** (All sections required – please print clearly.)

Name (last, first, middle initial) \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

- Request to Opt-Out:** I request that my health information be excluded from Epic Care Everywhere.
- I understand this means that other healthcare providers will not be able to obtain my health information through Epic Care Everywhere. My healthcare providers can still obtain my medical records through other methods.
  - I understand that any information that was shared through Epic Care Everywhere previously will remain available to providers who have access.
  - I understand that opting out of Epic Care Everywhere may cause a delay with my health information being disclosed to outside providers, including in emergency situations.
  - I understand that opting out of Epic Care Everywhere for UW Medicine will also mean opting out of Epic Care Everywhere for Seattle Cancer Care Alliance (SCCA).
- Request to Cancel (Rescind) Opt-Out:** I request to cancel my previous decision to opt out. By completing and signing this form, I am allowing my health information to be shared with my non-UW Medicine healthcare providers through Epic Care Everywhere as permitted or required by federal or state law.
- I understand that rescinding my request to opt-out at UW Medicine will also rescind the opt-out for Seattle Cancer Care Alliance.

This form can be sent to us as noted on **page 2**. Be advised that there are inherent risks with sending unencrypted emails, including the risk that such communications could potentially be intercepted and read by third parties.

Please allow up to 5 business days after receipt for processing the form.

Patient (or legal guardian) Signature:	Date:	Time:
Patient Name (printed):	Legal guardian printed name (if applicable):	

**UW Medicine**

Harborview Medical Center – University of Washington Medical Center  
UW Medicine Primary Care – Valley Medical Center – UW Physicians

**EPIC CARE EVERYWHERE PATIENT OPT-OUT**

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PLACE PATIENT LABEL HERE



**Harborview Medical Center and Clinics**  
**UW Medical Center and Clinics - Montlake**  
**UW Medical Center and Clinics - Northwest**  
**UW Medicine Primary Care Clinics**  
**Hall Health Center**  
Mail: 325 Ninth Ave, Box 359738  
Seattle, WA 98104  
Fax: (206) 744-9997  
Phone: (206) 744-9000  
Email: uwmedroi@uw.edu

**Valley Medical Center and Clinics**  
Mail: Release of Information  
400 S. 43<sup>rd</sup> Street  
P.O. Box 50010  
Renton, WA 98058  
Fax: (425) 690-9407  
Phone: (425) 690-3406  
Email: RecordsRequest@valleymed.org

UW Medicine Staff Only
Date received: _____
Processed by: _____

**UW Medicine**  
Harborview Medical Center – University of Washington Medical Center  
UW Medicine Primary Care – Valley Medical Center – UW Physicians

**EPIC CARE EVERYWHERE PATIENT OPT-OUT**  
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PLACE PATIENT LABEL HERE