Valley Medical Center Epic Care Everywhere Patient Opt-Out

Valley Medical Center (VMC) 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.

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.

☐ **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-VMC healthcare providers through Epic Care Everywhere as permitted or required by federal or state law.

This form can be sent to us as noted below. 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.

Valley Medical Center and Clinics

Mail: Release of Information
400 S. 43rd Street
P.O. Box 50010
Renton, WA 98058

Fax: (425) 690-9407
Phone: (425) 690-3406
Email: RecordsRequest@valleymed.org

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

Valley Medical Center Staff Only

Date received: _____

Processed by: _____

Patient Label