PATIENT BRIDGE

Individual Participation Change Request

Patient Bridge (PATIENT BRIDGE), a Health Information Organization (HIO), assists health care providers who participate in PATIENT BRIDGE share health information for treatment purposes through secure, electronic means. Having access to up to date and complete information from other caregivers can help a health care provider who is taking care of you. Information shared through the HIO is not a complete medical record of your health history, and the HIO is not the only source where health care providers may access or share your health information.

The purpose of this Participation Change Request is to permit you to request that PATIENT BRIDGE restrict sharing of your health information for treatment purposes between your health care providers through the HIO. This form does not guarantee PATIENT BRIDGE or your health care providers will not access or share your health information for other purposes as set forth in your health care provider's Notice of Privacy Practices.

Please initial that you have read and understand the following statements:

___________ I understand this Participation Change Request is only a request. PATIENT BRIDGE and/or my health care providers are not legally required to agree to any request for restriction. In the event PATIENT BRIDGE agrees to this request, PATIENT BRIDGE and/or my health care providers may continue to access or share my health information as set forth in my health care provider's Notice of Privacy Practices.

___________ I understand this Participation Change Request applies only to sharing of my health information through PATIENT BRIDGE for treatment purposes. I understand when I seek treatment from a health care provider, my treating provider may request and receive my health information from other providers or sources using other methods permitted by law, such as fax or mail.

Select one action:

__________ I request PATIENT BRIDGE restrict sharing of my health information for treatment purposes through the HIO.

__________ I terminate my previous request and authorize PATIENT BRIDGE to allow sharing of my health information for treatment purposes through the HIO.

Patient Legal First Name	Middle Name	Last name
Other names used (maiden name, nicknames, etc)		
Street Address		
City	State	Zip Code
Phone Number	Date of Birth (MM/DD/YYYY)	Last 4 digits of patient's Social Security Number

Parent / Guardian / Personal Representative Name	Relationship to Patient

____ ___________________________

Signature of Patient or Patient Representative Date

IMPORTANT: *In order to validate your identity and complete the request, you can attach a valid copy of one of the following forms of photo identification: Driver's License, Passport, Permanent Resident Card, or other Government-issued photo identification document*

OR

the following section may be completed by your Health Care Provider or a Notary Public.

-------------------------------------Section below for use by a Notary Public or Health Care Provider-------------------------------------

State of _______________________ County of ____

The foregoing instrument was acknowledged before me this _______________ by _____________________________________.
(date) (name of person acknowledged)

Print Name: ____

Signature: ____
Health Care Provider or Notary

Notary Stamp if verified by Notary

Please fax this form with ATTN: Patient Bridge Opt-Out to 972-905-7919