Cancellation of prior GNHCC-HIE Opt-Out form

Name:					
Date of birth:					
Street address:					
City:		State:		Zip:	
Phone:		E-mail:			

I hereby acknowledge and agree as follows:

1. I WISH TO cancel my prior decision to Opt-Out of the Greater Newark Health Care Coalition HIE (GNHCC-HIE), and now I specifically AUTHORIZE my information maintained in the GNHCC-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 GNHCC-HIE will have access to my health information maintained in the GNHCC-HIE;

3. I UNDERSTAND that by making this selection, my health information may be accessible by other HIEs with whom the GNHCC-HIE participate;

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

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

6. This request can take 2-3 business days to take effect.

Signature: ______________________ Date: ______________________

If Legal Rep, state Authority : ______________________________________

This completed and signed Cancellation of GNHCC-HIE Opt-Out form can be can be sent to support@greaternewarkhcc.org or mailed to:

Greater Newark Health Care Coalition HIE Administrator
c/o Greater Newark Health Care Coalition
80 Main Street, Suite 210
West Orange, NJ 07052