

**OPT-OUT OF SHARING PROTECTED HEALTH  
INFORMATION THROUGH HEALTH  
INFORMATION EXCHANGES**

By completing this form, you are requesting to be opted out of health information exchanges (HIE) for treatment purposes. HIE allows health care professionals and patients to access and securely share a patient's protected health information electronically. HIE enables VA to share patient information with community providers and other HIE partners. Opt-out means that none of your health information can be shared through HIE for your treatment except in a life-threatening medical emergency. Opt-in means that all of your health information can be shared through HIE for your treatment. Your disclosure of the information requested on this form is voluntary. A decision to complete the form will not have any effect on any benefits to which you may otherwise be entitled, however, you will not be able to participate in HIE. Because VA uses the Social Security Number (SSN) to electronically locate patient records, you need to provide your complete and accurate SSN in order for us to carry out your request to opt-out.

**PRIVACY STATEMENT:** Your disclosure of the personal information requested on this form is voluntary. However, if the information containing the Social Security Number (SSN) (the SSN will be used to locate records) is not furnished completely and accurately, the Veterans Health Administration (VHA) will be unable to comply with your request. By completing this form, you will be opted out of the electronic exchange of health information for treatment purposes. Failure to furnish the personal information will not have any effect on any other benefits to which you may be entitled; however, you will not be opted out of information exchange. Consistent with the VA Notice of Privacy Practices, VA may also use the information on this form for purposes other than your treatment as authorized or required by law. The information collected on this form is part of a Privacy Act system of records, "Virtual Lifetime Electronic Record (VLER)-VA", 168VA10P2. The personal information requested on this form is solicited under Title 38, U.S.C. 501.

**VETERAN'S FULL NAME:**

LAST ( <i>Print</i> )	FIRST	MIDDLE	9-DIGIT SSN
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**OPT-OUT**

By signing this form, I understand that I am directing VA to opt me out of electronic sharing of my health information with HIE partners. By signing this form, I am agreeing that my health information will no longer be shared electronically with partners through HIE for their treatment of me except in a life-threatening medical emergency. My health information will continue to be shared for my treatment on paper or through fax or other legally allowed means other than HIE. I certify that I am making this opt-out request freely, voluntarily, and without coercion. This opt-out decision will be in effect unless and until I cancel it by authorizing VA to opt me in to HIE in writing on VA Form 10-10163.

*If you decide that you would like to be opted back in to the sharing of your health information, you will need to contact the Release of Information Office at the VA Medical Center where you receive treatment or call the Health Eligibility Center (HEC) Call Center at 1-877-771-VLER (8537).*

**SIGNATURE:**

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Legal Representative (*if applicable*)

\_\_\_\_\_  
Date

To Sign for Patient (*Attach authority to sign: Health Care Power of Attorney or Legal Guardian*)

\_\_\_\_\_  
Name of Legal Representative (*please print*)