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Care Everywhere Refusal ("Opt-out")

Care Everywhere® is a system we use to share your personal health information. Health care providers who have electronic health records and have *Care Everywhere* can share your health information. *Care Everywhere* is a fast, safe, and effective way for us to share your health information with other hospitals, clinics, and labs.

We are sharing your information now.

If you do not want any UR Medicine facility or provider to share or receive your health information using *Care Everywhere*, please complete this form and mail it to the address at the bottom of the page. (You may want to make a copy of this form and keep it for your records before mailing.)

Questions? Please call the UR Medicine Health Information Management (HIM) office at (585) 275-2605.

You can change your mind any time by contacting the HIM office.

No

I do not want you to share/receive my medical information using *Care Everywhere*.

*Patient's name (please print): _____

*Date of birth: _____ Medical record #: _____ (optional)

**This information is required.*

☐ When you check this box, it means you do not want any UR Medicine facility or provider to share your medical information using *Care Everywhere*. You understand that other health care providers who use *Care Everywhere* will not be able to see your UR Medicine medical information.

☐ When you check this box, it means you do not want any UR Medicine facility or provider to receive your medical information using *Care Everywhere*. You understand that our UR Medicine health care providers who use *Care Everywhere* will not be able to receive your medical information from other hospitals.

Please note: There are other ways information is shared between health care systems that will still occur when required by law. There may also be additional choices for your information. If you have questions, please contact the HIM office at the number above.

_____ _____

Patient's signature or signature of patient's legal representative | Date and time

_____ _____

(If you signed as legal representative, print your name here.) | (Relationship to patient)

Please mail this completed form to:

University of Rochester Medical Center
Health Information Management Department
601 Elmwood Avenue, Box 616
Rochester, NY 14642