Patient Name: _____

Date of Birth: _____

Medical Record #: _____

Place Patient Label

RUSH

COMBINED OPT-OUT FORM

HIPAA Privacy Patient Rights-P

IDN13150017

Rush University Medical Center, Rush Oak Park Hospital, Rush Copley Medical Center, and Rush Health (collectively known as "Rush") participate in several platforms that provide the ability to electronically exchange patient information for uses authorized under the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state laws. These exchanges permit the secure electronic sharing and access to your protected health information (PHI) by authorized healthcare organizations and providers (covered entities) to have the most up-to-date information about you. If you do not want your information shared in this way you may opt out by indicating your selection on this form. If you opt out, you also have a right to opt back in at any time by completing this form.

Below please indicate your preferences to:

Opt Out: I request that my RUSH health information be excluded from the services indicated. I understand this means that other health care providers will not be able to obtain my health information through these services except to the extent action has already been taken to release information, and they may still obtain it through other methods.

Reverse Opt Out: I previously chose to Opt Out of the selected services and not allow my Rush health information to be electronically available to other health care providers. I am now choosing to participate (Opt In) and allow my Rush health information to be electronically available. By checking this box and signing this form, I am reversing my prior request to exclude my health information from the indicated services.

Care Everywhere	Sharing of the electronic patient record to other external healthcare entities that are also using Epic	_____ Opt Out _____ Reverse Opt Out
Cures Act ADT	Electronically sharing of your information regarding new admissions to your Primary Care Provider (PCP)	_____ Opt Out _____ Reverse Opt Out

First Name: Middle Initial: Last Name: Email Address:

Street Address: City State Zip Code

Date of Birth (month/day/4-digit year) ____/____/_____ Sex: ☐ M ☐ F Telephone number(s): (_____) _____–_____

Signature of patient: Date:

Personal Representative – if you are the patient's personal representative, please indicate your relationship to the patient:

☐ Parent of minor patient ☐ Guardian of patient ☐ Other, explain: _____

Signature of Personal Representative of patient (if authorized to opt out on behalf of patient):

Completed forms should be returned to the Privacy Office at 707 S. Wood Street, #317, Chicago, IL 60612 or Fax: (312) 942-6875. Please contact the Privacy Office at (312) 942-5303 with questions.