REVOCATION OF PRIOR
ATLANTICARE KeyHIE® OPT-OUT

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 AtlantiCare HIE, and now I **specifically AUTHORIZE** my information maintained in the KeyHIE® 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 KeyHIE® or are connected to the KeyHIE® will have access to my health information maintained in the KeyHIE® ;

3. I understand that by making this selection, my health information may be accessible by other HIEs with whom the KeyHIE® participates;

4. I understand that this cancellation can only be changed if I specifically submit a new KeyHIE® Opt-Out form;

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

6. This request can take **5 business days** to take effect.

Signature:_____ Date:_____

If Legal Representative, state Authority: _____

Submit by fax to: (609) 441-2111
Mail to: AtlantiCare HIM Operations, 1925 Pacific Ave, Atlantic City, NJ 08401 or
E-mail to: HIMDataIntegrity@atlanticare.org