



SMRTNET OPT-OUT REQUEST

SMRTNET (Secure Medical Records Transfer Network) is a secure health information exchange designed to improve your medical safety, save time, and potentially decrease some of your medical expenses. SMRTNET exchanges your health information only between your current providers who are also members of SMRTNET. SMRTNET is compliant with the same state and federal laws which regulate the faxing, mailing and electronic exchange of medical information. No information is shared with employers, credit companies, law enforcement, mortgage companies or anyone else not actively seeing you for treatment and also a registered member of SMRTNET. All SMRTNET services are offered to patients at no charge. It is extremely important for you and your family to have your provider see all of the medications, illnesses and conditions, allergies and reactions, lab tests and immunizations during your medical visits. This is especially true in emergencies. If your provider does not have access to your information you may be prescribed the wrong drug, treated for the wrong illness, or bear extra expense and time to have tests and procedures repeated.

Even though there are many benefits to allowing your health care providers to see your health history through SMRTNET, you may opt-out of SMRTNET and your information will not be exchanged through SMRTNET. If you opt-out of SMRTNET, none of your SMRTNET health information will be available and your health provider will not be able to see your past health information such as drug allergies, and tests through SMRTNET. Your provider will then have to contact each of your providers individually and await their response by mail, phone, or fax which may delay your care.

SECTION A: Please provide the following information on the individual opting out of SMRTNET (if you are opting out your dependent under age 18 or someone for whom you are an authorized representative, enter that person's name and information here):
(** required fields)

| | | | | | |
|------------------------|-----------------------------------|-------------|---------------|----------|--------------|
| Last name | First name | Middle name | Date of Birth | | |
| Street Address | | City | State | Zip Code | Phone Number |
| Social Security Number | Aliases (Nicknames, Maiden names) | | | | |

SECTION B: Please read the following and complete the information requested.

You have the right to opt-out of having your health information exchanged among your health care providers through SMRTNET. If you opt-out, SMRTNET will not share any of your health information, unless you later revoke this opt-out request. When SMRTNET receives this opt-out request, SMRTNET will make it effective as soon as administratively feasible (usually within 5 business days after SMRTNET receives this request).

OPT OUT: I do not wish for any of my health information to be exchanged between my health care providers using SMRTNET. I understand that if I opt-out, none of my health information will be available on SMRTNET. I also understand that without the health information on SMRTNET, my health care providers may not have health information easily available to them that would help them treat me.

NOTE: This opt-out only prevents your health information from being exchanged through SMRTNET. It does not prevent your individual health care providers from exchanging your health information directly between one another or through other means. If you wish to prevent these other exchanges, you should contact your health care providers directly.

SECTION C: Signature and Date:

Signature of Patient or

Authorized Representative*: _____ Date: _____

Authorized Representative's Address, City, State, Zip Code

*Authorized Representative means you have legal proof you can act for the individual named in this Opt-Out Request and a copy must be attached to this Opt-Out Request. An authorized representative for a child under age 18 is generally the child's parent or legal guardian. An authorized representative for someone over age 18 is typically an attorney-in-fact or legal guardian for that individual.

Please sign and mail form to:

**P. O. Box 2140
Tahlequah, OK, 74465**

Or send by fax to: (888) 408-2465

| | | |
|---|---------------------------|------------------------------|
| Office Use: Received Date: _____ | Received By: _____ | Date Effective: _____ |
|---|---------------------------|------------------------------|