

# Health Information Exchange (HIE) Patient **Opt-Out** Form



Last 4 Digits of Social Security Number: \_\_\_\_\_

\_\_\_\_\_  
First Name

\_\_\_\_\_  
M. Initial

\_\_\_\_\_  
Last Name

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date of Birth (mo/da/yr)

Gender:  Male  Female  Prefer not to say

\_\_\_\_\_  
Street Address 1

\_\_\_\_\_  
Street Address 2

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Country

\_\_\_\_\_  
Telephone Number

## Opt-Out of Health Information Exchanges:

I do not want my Palomar Health medical information electronically shared through Health Information Exchanges.

**\*By signing as a legal representative,  
I am certifying that I am legally authorized  
to act on behalf of the patient.**

Your opt-out request will be effective  
approximately ten business days after  
Palomar Health receives your request.

**For questions, call Palomar Health at 760.480.7901.**

**Palomar Health patients can  
e-mail the form to [HIE@PalomarHealth.org](mailto:HIE@PalomarHealth.org)  
or mail to:**

**Palomar Health  
Privacy Office  
120 Craven Road, Suite 224  
San Marcos, CA 92078**