Charleston Area Medical Center

CommonWell Health Alliance® services ("CommonWell") Patient Opt-Out Form

Please print, complete and mail to:

Charleston Area Medical Center
Attn: Health Information Management Department, HIE
130-138 57th Street
Charleston, WV 25304

____ Charleston Area Medical Center may not share any of my health information with CommonWell.

By completing this form, I certify that I have been notified of the benefits of participating in CommonWell and of my right to opt out of having my data shared between participating health care providers through the CommonWell. I also understand that opting out of CommonWell will not affect my ability to access medical care, and my personal health information may still be shared with authorized entities and used in certain circumstances pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and state law.

Last Name: _____ **First Name:** _____

Email: _____ **Primary Phone #:** _____

Date of Birth: _____ Last 4 Digits of Social Security #: _____

Street Address: _____

City: _____ State: _____ Zip: _____

If this form is submitted by someone other than the person named above, the person submitting the form hereby certifies that he/she is acting as (check one)

☐ Parent
☐ Legal Guardian
☐ Other: _____(Relationship)

_____
Signature