Puerto Rico Health Information Exchange (PRHIE)

Opt-Out Form

Please select the corresponding check box, complete the form, and sent to: participantes.prhie@salud.pr.gov

☐ **PRHIE cannot disclose my health information on the Patient Portal**

By completing and signing this form, I certify that I have been notified of the benefits of the Puerto Rico Health Information Exchange and of my right to opt out of having my data shared among health care providers through the PRHIE. I understand that a disclosure of Protected Health Information may be required by law in certain situations. For example: reporting of communicable diseases, child abuse, domestic violence, attempted suicide, national security, public health emergency, etc.

Patient or Legal Guardian Signature _____ Date (mm/dd/yyyy) _____

Name (Print) _____ Relationship _____

☐ **I request that my nondisclosure decision be canceled**

By completing and signing this form, I am allowing my medical information to be accessible to my health care providers through the PRHIE. I understand that upon reactivation of my service I am limited to not making another opt-out for a period of one (1) year.

Patient or Legal Guardian Signature _____ Date (mm/dd/yyyy) _____

Name (Print) _____ Relationship _____

Please complete all fields for the patient requesting non-disclosure or cancellation of non-disclosure. Incomplete forms will not be processed.

Name and Last name _____ Date of Birth (mm/dd/yyyy) _____

Address _____

City _____ State _____ Zip Code _____

XXX-XX- _____ _____

Social Security Number (last 4) Email

( ) _____ ( ) _____

Primary Phone Alternate Phone

For more information you can access www.salud.pr.gov/PRHIE