Madison Memorial Hospital ● Madison Memorial Rexburg Medical Clinic ● Madison Surgery Center
Madison Memorial Orthopedics ● Seasons Medical by Madison Memorial Hospital ● Madison Memorial Outpatient Services

Request to Restrict Disclosure of Health Information

(Health Information Exchange)

You may want to consider the benefits of having your health information available through the Health Information Exchange (HIE) before submitting this form. The mission of the Exchange is to improve the coordination and quality of health care across Idaho and the country. Health information in the Exchange provides healthcare providers and medical staff with a quick snapshot of your current and past health to make more informed decisions about your care. This is valuable in an emergency situation if you might not be able to communicate. Having this information quickly available also helps to reduce medical errors and duplicate tests.

Only Exchange participants have secure access to your medical records in the HIE. These participants may ONLY access data for purposes of treatment, payment, and healthcare operations which promote efficiency of communication in care, patient safety, and enhance patient health. These participants also have to abide by the Exchange's programs and policies, which include HIPAA privacy and security standards. Use of the HIE system for any other reason is strictly prohibited.

You can choose whether to make your health information available to providers participating in the HIE. If you request a restriction, also known as "Opting Out", only your name, date of birth and gender will be available to participating providers.

If you decide you do not want your health information or your minor child's health information made available through the HIE, mail or fax this form to the address or fax number below. Keep a copy of this form for your records. You will receive a letter confirming your request. If you decide later that you want to make your health information available through the HIE, you must complete a Request to Rescind (opt back in) form to withdraw your request.

Please check the appropriate box:

□ I do not want my health information made available to participants in the CommonWell Health Alliance.

□ I do not want my child/guardian child's health information made available to participants in the CommonWell Health Alliance.
*(Minors will automatically be opted back in to the exchange upon turning 18)

Please print

Patient Legal First Name	Middle Initial	Last Name	
Other names you have used (maiden name, etc.)			
Street Address			
City		State	Zip Code
Phone #	Date of Birth (MM/DD/YYYY)	Gender ☐ M ☐ F	Last 4 digits of patient's SSN
Parent/Guardian/Personal Representative Name (Please print)			Relationship to Patient
Patient or Parent/Guardian Signature			Date

Mail to: Privacy Officer, 450 E Main, Rexburg, ID 83440

Fax to: 208-359-6413
Attn: Privacy Officer