Connie
Connecting People for Better Health

Health Information Exchange Patient Opt-Out Form

This form is to be used by patients who do not wish to participate in Connecticut's statewide Health Information Exchange (HIE).

A health information exchange, or HIE, is a safe electronic way for health care providers and organizations to share clinical information about their patients. In Connecticut, the state-wide HIE is called Connie. When you need to receive care, it is critical that your health care provider have the most recent information about your health. Your provider can search the HIE for your health information to use while taking care of you.

You may follow the directions below to opt out of sharing clinical information through Connie. Your health information will be deleted from Connie within 5 business days. Once your data is deleted, your provider will not be able to search Connie for your health information. However, some providers will use Connie to send information about their patients to each other directly. This is the same as when providers share information by fax or by mail.

If a provider searched Connie for your information and put that information into their medical records before you completed your opt-out, that information will remain in that provider's medical records.

There are exceptions. Public health reporting, such as the reporting of infectious diseases to public health officials, will still occur through the HIE after you decide to opt out. Also, Controlled Dangerous Substances (CDS) information, as part of the Connecticut Prescription Drug Monitoring Program, will continue to be available through the HIE to licensed providers.

You do not have to fill out this form every year. You only need to fill it out once for yourself. You do not need to fill this out for each provider you have. We will keep this information and your decision in place until you decide to opt back in. If you don't live in Connecticut but you see a provider here, you should complete this form to opt out.

If you change your mind and want to share your clinical information, we are happy to help. Please call us at 866-987-5514 so that we can make that change for you. Unfortunately, we cannot retrieve the information we deleted when you opted out so your historical clinical information will not be in Connie.

You have several options for opting out of the Connie Health Information Exchange. Please select one below.

1. Visit the Connie Web site at http://www.conniect.org (preferred)
2. Fill out this form and email your completed form to help@conniect.org
3. Fill out this form and fax your completed form to 443.817.9587
4. Fill out this form and mail it to: Connie, 10 North Main Street, Suite 6 West Hartford, CT 06107*
5. Call 1.866.987.5514

**Please note, due to COVID, any mailed forms may cause a delay in processing.*

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This form is to be used by patients who do not wish to participate in Connecticut's statewide Health Information Exchange (HIE).

Please complete this form if you do not want to share your clinical data in Connie, the statewide health information exchange.

Information for Patient Opting Out (Please PRINT Clearly)

*All fields marked with an * are required. You must be 13 years or older to fill out this form.*

First Name* ______________________________

Middle Name ______________________________

Last Name* ______________________________

Address Line 1* ______________________________

Address Line 2 ______________________________

City* ____________________ State* ______ Zip Code* ____________

Primary Phone Number* ______________________________

Secondary Phone Number ______________________________

Email ______________________________ Date of Birth* ____________

Sex* Male Female Other/Do not wish to Disclose

I would like to be notified of my participation choice in the following way (contact information must be included on form): Text Phone Call Email Letter No Notification

Note: if you selected email, be sure to provide your email address above. If you selected "text", make sure the phone number provided can receive text messages.

Reason for Opting Out (optional): ______________________________

If this form is signed by someone other than the person named above, the person signing the form hereby certifies that he/she is acting as: (CHECK ONE)

Parent Legal Guardian Other (Specify Relationship of the person named above) ____________

Contact Information for Individual Completing This Form If Other Than Patient (Please Print Clearly)*

Printed Name ______________________________ Phone Number ____________

Patient Information (Please Print Clearly) *

Printed Name ______________________________

Signature ______________________________ Date ____________