ANMC CommonWell Information for Opt-Out

The Alaska Native Medical Center has partnered with CommonWell Health Alliance® Services, a national network of organizations aligned to streamline the secure sharing of health data with a goal of improving care coordination and health outcomes.

When you are seen at ANMC you are automatically enrolled in CommonWell unless you decide to "opt-out" by completing the CommonWell opt out/back in form. If for any reason the patient decides they want to opt back in they would use this form as well.

Participating in CommonWell can improve your health care experience and save you time by:

- Allowing your different doctors, primary care providers, specialists, hospitalists, and other clinicians more secure and near instant access to your important health information.
- Reducing time required to track down test results and other health information, increasing the time your healthcare providers can spend on your care, and potentially removes the need for duplicate tests.
- In the event of an emergency, medical staff can immediately access your allergies, medication list and other health information, helping to expedite your care.
- Electronic sharing is more secure than fax or paper files, which can easily be lost or viewed by individuals without proper authorization.
- Saving time and the hassle of filling out the same health history forms repeatedly when you see your doctor or go to a specialist.

The security of your health data is one of our most important priorities. Your personal health information is only made available via appropriate technical, administrative and physical security safeguards to the permitted recipients participating in the alliance network.

You May Opt-Out Or Opt Back In To CommonWell By Completing The Form On The Next Page

Although there are benefits to being enrolled, you have a right to opt-out.

- You may opt-out by submitting the completed opt-out form to your Clinic or the ANMC Registration Department.
    - **Email**: akacentralregistration@anthc.org
    - **Fax**: 907-729-1396
    - **Mailing Address**: 4315 Diplomacy Drive, Attn: Admitting; Anchorage, AK 99508

- If you opted out and wish to opt back in you can indicate as such on the form.
- Opting out does not preclude any CommonWell participating organization that has previously accessed your health information from retaining this information within their own records.
- Also, opting out here only stops the sharing of data between ANMC and CommonWell. If you have received care at another facility who has partnered with CommonWell, you will need to contact that organization to manage how you'd like them to share your records with CommonWell.

ANMC CommonWell Opt Out/Back In Form

Patient Name – Last	First	Middle Initial	Date of Birth / /
Maiden Name		Suffix	
Email:			

I understand that I may choose to change my Opt Status of electronically sharing my health information through CommonWell and that I may elect to opt out of CommonWell for any reason, or I may elect to opt back in for any reason. I understand that if I opt out, my health information may not be accessible to my care provider *even in an emergency*.

I understand that CommonWell is not responsible for electronic information sent by mistake or in error from ANMC or other participating organizations. Information in CommonWell representing my health record and me may still be accessible in or shared by CommonWell and it is my responsibility as the patient to notify my providers of any errors regarding my information. Errors may include but are not limited to misspelling of names, i.e., "**John** Doe" versus "**Jon** Doe," incorrect date of birth, etc.

I understand that ANMC participates in CommonWell under the name ***Alaska Tribal Shared-EHR***. If I see another health care provider who would like to view my health records, I should share this name with them so they can locate those records. This name includes records from ANMC and from other health care providers that share an electronic health record with ANMC, including many of the regional tribal health organizations.

I hereby certify that I have also read and understand the above information.

☐ **I elect NOT TO PARTICIPATE in the CommonWell Health Information Exchange at this time (OPT-OUT)**

☐ **I elect TO PARTICIPATE in the CommonWell Health Information Exchange at this time (OPT-IN after a prior opt out)**

Patient Signature: _____ Date: _____ Time: _____ AM / PM

If patient is unable to sign or is a minor, a patient representative must sign:

Representative Signature: _____ Date: _____ Time: _____ AM / PM

Representative Name: _____

Relationship to Patient: _____