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Note to the Health Care Provider: Please assist the minor patient in completing this form and send it to the following Direct Secure Message address **within two days of the patient's visit**: MinorOptOut@direct.moo.nchie.net. NC HIEA staff will acknowledge receipt via a secure, confidential email to the Local Health Department.

The NC HIEA may not share the health information created on the date listed below.

By completing and signing this form, I understand and acknowledge that:

- I have been notified about NC HealthConnex and of my right to opt out of having my information shared regarding prevention, diagnosis, and treatment for certain contagious diseases, including venereal diseases; family planning/pregnancy; emotional issues; and alcohol or drug use (Opt-Out Events) for health care services rendered on the date below.
- This form only applies to that information that could be shared through NC HealthConnex.
- My medical information may sometimes be seen even if I opt out if the law requires it.
- **Other health care providers will not have access to my medical information about prevention, diagnosis, or treatment provided to me for Opt-Out Events on the date below.**
- This information is not legal advice.
- ./4@'8'1+)' 153?$""34&@%1Y"%Y>%9D&5%&@'+"$%4&5%1@5<&+%/$5PSA78?1>'B$5%%1"%1>%'802' 6&$3%/2155&:15;& ?1>'%>+5PSE%/&5?1>+'/&$3%/;$+&'"+1D4#&;$5' @>""3??1>'B4%$' @&"$+$%&'W D Q1G%D1%8'1+)EB/4;/' B43C'&&" ?1>+)$3+'&;1+#@8'+1)'*&45<D4@4*4&802'6&$3%/2155&:A

List the date of the visit when you received treatment for contagious diseases, family planning/pregnancy, emotional issues, or drug or alcohol use (Opt-Out Event) that you do **not** want to be viewed in NC HealthConnex:

______________________________	______________________________
Month / Day / Year of Opt-Out Event	Signature of Minor Patient
MinorOptOut@direct.moo.nchie.net	______________________________
	Printed Name of Minor Patient
	______________________________
	Date Signed

THIS SECTION TO BE COMPLETED BY THE PROVIDER

Including the minor patient's email is optional and will only be used by NC HIEA to send a message confirming that a request has been processed. Please do not include an email account that is accessible by anyone who the minor does not want to know about the opt-out.

______________________________ ______________________________
Patient's Medical Record Number Local Health Department Name and Organization NPI

______________________________ ______________________________
Local Health Department Contact Name Local Health Department Contact Phone Number

____
Patient First Name Patient Middle Name Patient Last Name

____
Patient Street Address

____
City State Zip Code

______/______/____________ ________ ______________________________
Patient Date of Birth Sex Patient Email Address ***(optional)***

(_____)______________________ (_____)____________________
Primary Phone Number Secondary Phone Number