OPT-OUT REQUEST FORM

HUSKY Health would like to do everything possible to help coordinate your health care. For this reason, unless you don't want us to, HUSKY Health will let your primary care provider (PCP), the specialist who manages your care, and the hospital where you usually go, see your health information electronically.

If that is fine for you, you do not need to do anything and you do not need to send in this form.

Please sign and send this form to HUSKY Health at the address below ONLY if you do NOT want:
☐ **Your PCP** ☐ **Your specialist** ☐ **Your hospital** *[check the box(es) that apply]*
to see any electronic health information that HUSKY Health has about you from other providers. If you send back the form and don't check any of these boxes, we will not allow any of these providers see your information.

STEP 1: List the members in the household who are 18 years old or older who do not want the provider(s) checked above to see their electronic health information from other health care providers (**Note that each adult who is listed must sign below**):

1	Last Name	First Name	Date of Birth (MM/DD/YYYY)	HUSKY ID#
2	Last Name	First Name	Date of Birth (MM/DD/YYYY)	HUSKY ID#
Street Address		Apt. #	City, State, Zip	
Phone Number		Email Address		

STEP 2: List the members in the household who are under 18 years old for whom you do not want the providers checked above to see their electronic health information from other health care providers:

Last Name	First Name	Date of Birth (MM/DD/YYYY)	HUSKY ID#
Last Name	First Name	Date of Birth (MM/DD/YYYY)	HUSKY ID#
Last Name	First Name	Date of Birth (MM/DD/YYYY)	HUSKY ID#
Last Name	First Name	Date of Birth (MM/DD/YYYY)	HUSKY ID#

STEP 3: Sign as Head of Household or other adult member:

By signing this form and opting out, you are saying that you do NOT want HUSKY Health to electronically share health information it has about you, and/or your children, as listed above, which it gets from other providers, with the providers you checked above, even though the information will be used by such providers for treatment and care management purposes only:

1	Signature of Member or Member's Legal Representative	Printed Name of Person who Signed	If Legal Representative, Relationship to Member	Date
2	Signature of Member or Member's Legal Representative	Printed Name of Person who Signed	If Legal Representative, Relationship to Member	Date

HUSKY Health, Attention: Compliance, P.O. BOX 5005, Wallingford, CT 06492, 1.800.859.9889

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