PhoebePatient

Patient Portal Opt-Out Form

Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ E-Mail: _____

The Phoebe Patient Portal is a convenient and secure health-management tool you can use anywhere you have access to the Internet.

After considering my option of participating in Phoebe Patient Portal, I have decided to OPT OUT and NOT participate in Phoebe Patient Portal. By choosing to OPT OUT of Phoebe Patient Portal, I hereby acknowledge and agree as follows:

1. Opting out of Phoebe Patient Portal may delay access to important medical information.
2. My health information will not be shared by facilities in the Phoebe Putney Health System. Instead, my information will be shared via previously established methods, such as phone, fax, or mail.
3. Any information that is shared before I submit this Patient Portal Opt-Out form may remain with facilities within Phoebe Putney Health System who accessed information before this Opt-out went into effect.
4. My **Phoebe Patient Portal Opt-Out** selection will remain in effect unless I change it in writing; and
5. This request can take up to 3-5 **business days** to take effect.

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 _____ for the person named above.

Printed Name: _____ Date: _____

Signature: _____

Please forward the completed and signed Phoebe Patient Portal Opt-Out Form to Phoebe Putney Health Systems, Inc. by one of the following methods:

1. Fax to : _____
2. Email to: _____