Application Form to Opt Out of the National Health Information Exchange Network, Over 18 Years Old

Applicant's Declaration

I _____ _____ ID No. ☐☐☐☐☐☐☐☐-☐

Given Name Surname

Gender: M/F Date of Birth: _____ Address: _____

Insured in HMO (Kupat Cholim) _____ hereby declare that:

1. I have read the information sheet, and have understood the following:
   a. That the National Health Information Exchange Network allows the display of medical information to a treatment provider in hospitals throughout Israel from my medical file stored in the information systems of the institutions in which I have been treated - other hospitals and the HMO (kupat cholim).
   b. Systems to protect the confidentiality of information have been set up in the information exchange system, and the system monitors each viewing of my medical file and documents it.
   c. The significance of a request to opt out of the network is that the medical information about me (from other hospitals and the HMO-kupat cholim) that is available through the information exchange network will not be available to those treating me, and the treatment provider will have to rely exclusively upon information that I will provide regarding my medical history, medications that I am taking, sensitivities to medications, etc. In case I will not be able to provide the treatment provider with the above-detailed information, the party treating me will not have access to medical information about me from other organizations.
2. I understand that it is my personal and full responsibility to inform the treatment providers of the needed medical history, including sensitivities, the medications that I am taking, medical procedures that I have undergone, test results, and similarly, all other medical information.
3. I am aware that after my request is carried out, information about me will be removed from the network in its entirety, and that it is not possible to opt out partially or to remove only a portion of the information. In all events, it will not be possible in hospital to view information that exists about me in other health organizations.
4. I am aware that in spite of opting out of the network, a summary of emergency room visits or of hospitalizations will continue to be sent from the hospital to the insuring HMO (kupat cholim), as has been the case until now, irrespective of the medical information exchange network.
5. In spite of being aware of the possible implications, I request to be removed from (opt out of) the information exchange network.
6. If I will wish to change my mind and to be included in the information exchange network, I will have to sign an application form for reinstatement (to opt back in) at a branch of the HMO-kupat cholim (or through the "mikol halev" call center for a soldier in the standing army).
7. My actual removal from the network will be carried out within 30 days of submission of the application to a branch of the HMO-kupat cholim (or to the "mikol halev" call center).
8. On transfer between HMOs (kupot cholim) and at the time of being discharged from the standing army, I will have to resubmit the request to opt out of the network at the HMO (kupat cholim) to which I transfer, this being for the HMO's administrative requirements.

Name: _____ Signature: _____ Date: _____

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Telephone number for clarifications (not compulsory): _____

Email address for clarifications (not compulsory):_____@_____

Signature Verification

I, the undersigned _____ Position: _____

Branch: _____ District: _____

Given Name Surname

appeared before me and identified him/herself using an identity document, received an information sheet about the National Information Exchange Network and about the significance of opting out of the network, and signed this form in my presence.

Name: _____ Signature: _____ Date: _____