



# Bureau of TennCare

## Opt-Out Request

**After you fill out and sign this paper, send it to:** Shared Health  
 Attn: Compliance  
 P.O. Box 751  
 Chattanooga, TN 37401-0751

Use this page **ONLY** to tell us you **don't** want your medical health facts to show in the Clinical Health Record™.

### 1. Who is the patient?

|                 |                            |                               |          |                |
|-----------------|----------------------------|-------------------------------|----------|----------------|
| Last Name       |                            | First Name                    |          | Middle Initial |
| ID Number (SSN) | Date of Birth (MM/DD/YYYY) | Phone Number (with area code) |          |                |
| Address         | City                       | State                         | Zip Code |                |

Check One

- I am the patient **OR**  I have the legal right to act for this person.  
 I'm his or her:  Parent **OR**  Guardian **OR**  Other (fill in blank) \_\_\_\_\_

TennCare uses the Clinical Health Record™ to send your health facts to your doctors' office computers. Health facts include information that identifies you, like your name and date of birth. It's also information about your health and health history. Having these health facts helps you and your doctors make better choices about your care. **Remember even if you sign this form:**

- TennCare will still have your health facts and can share them as allowed by privacy laws.  
 But your medical health facts **won't show** in this Clinical Health Record™.
- Health providers will **still** see your name, date of birth, or ID number. Your record will say you have decided not to show your medical facts.

### 2. Signature of Patient

I **don't** want to share my medical health facts in the Clinical Health Record™.

**Sign Here:**

|                                                                |                       |
|----------------------------------------------------------------|-----------------------|
|                                                                |                       |
| Signature or Mark ("X") of Patient                             | Date                  |
|                                                                | ( )                   |
| If signed "X" please tell us the person's name who helped you. | Helper's phone number |
|                                                                |                       |
| Helper's Address, City, State, Zip Code                        |                       |

### 3. Signature of Authorized Representative (if any)

**Authorized Representative** means you have legal proof you can act for this person. A representative signs for a patient who may not legally sign on his or her own. If the patient is less than 18 years old, a parent or guardian should sign for the minor. \*You must include a copy of legal proof with this page that says you can act for this person. If you don't include it now, you must send it to us within thirty (30) days.

|                                                  |       |
|--------------------------------------------------|-------|
|                                                  |       |
| Signature of Person signing on behalf of patient | Date  |
|                                                  |       |
| Printed Name                                     | Phone |
|                                                  |       |
| Address, City, State, Zip Code                   |       |