MIT Health

## Participating in CommonWell Health Alliance and Surescripts

# Objection (or Withdrawal of Objection) Form

**Patient information** *(this information is necessary to properly identify the patient):*

Name: _____

Date of birth (mm/dd/yyyy): ____ /____ /_____ Gender: _____

Address: _____

Phone number: _____ Email address: _____

**Parent/guardian information** *(required if form is completed for a child younger than 16 years of age):*

Relationship to patient: _____

Name: _____

Date of birth (mm/dd/yyyy): ____ /____ /_____ Gender: _____

Address: _____

Phone number: _____ Email address: _____

○ **I OBJECT** to sharing my health information though the CommonWell Health Alliance. I understand that this prevents my doctor or other healthcare providers from being able to electronically access my records for health information that comes from health providers outside of MIT Medical.

○ **I WITHDRAW MY PREVIOUS OBJECTION** to the sharing of health information through the CommonWell Health Alliance. I understand that by signing and submitting this form, other healthcare providers may view my health information as allowed by law.

**Signature of Patient, or Parent/Guardian** *(if child is younger than 18 years of age):*

Signature: _____ Date: _____

**Please print or scan and return to:** Medical Records
E23-023
medcor@med.mit.edu
Fax: 617-258-0884