### Patient's Right to "Opt Out" Form

**H-10488 3/19 (d/forms/hosp/ofm)**

**Patient:** ____________________________________

**Date of Birth:** ____________________________

**Requested by (if other than patient):** ___________________________________

**Requestor Contact Information:** ____________________________________________

**Patient/Requestor Signature:** __________________________ Date: ______________

> IF SOMEONE OTHER THAN THE PATIENT IS COMPLETING THIS REQUEST, PLEASE ATTACH CERTIFYING DOCUMENTATION OF YOUR STATUS AS THE PATIENT REPRESENTATIVE.

<table>
<thead>
<tr>
<th>My information may be used for:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Research studies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>We may use portions of your medical information for research purposes. For example, determine if you qualify to enter a clinical trial for a new medication or treatment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Fundraising</strong></td>
<td></td>
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</tr>
<tr>
<td>If you select yes, The Friends of Bassett may contact you as a part of a fundraising effort.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Marketing:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>New Services/ Appointment reminders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Information about treatment alternatives:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Most uses and disclosures for marketing purposes requires your authorization.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Patient Experience Surveys</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>We want to understand and learn from your experience at Bassett. Your feedback is important. We may send a survey either by standard mail, email, or phone by our survey vendor Press Ganey. Your input helps us to understand what we are doing well, and what we can improve for you and future patients.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Send copies to Information Privacy Security Office, Bassett Hall**

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**References:**
- Health Information Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information 45 CFR Part 164, Section: 164.510(A)
- Patient Privacy Program Requirements
- Community Clergy Access to Patient Listings under the HIPAA Privacy Standards Policy
- Notice of Privacy Practices
- Excluding Patients from the Patient Survey Process

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**BASSETT HEALTHCARE NETWORK**
- **A.O. FOX HOSPITAL**
  - Oneonta, NY 13820
- **BASSETT MEDICAL CENTER**
  - Cooperstown, NY 13326
- **COBLESKILL REGIONAL HOSPITAL**
  - Cobleskill, NY 12043
- **LITTLE FALLS HOSPITAL**
  - Little Falls, NY 13365
- **O’CONNOR HOSPITAL**
  - Delhi, NY 13753
- **A.O. FOX TRI-TOWN CAMPUS**
  - Sidney, NY 13838

**Clinic _______________________**