REVOCATION OF HIE OPT-OUT REQUEST FORM

This form is to be used by clients who wish to revoke a prior Opt-Out form

The Department of Health's participation in the Health Information Exchange (HIE) is a way of allowing your health information to be securely shared by participating hospitals, laboratories, and other health care providers through secure, electronic means. The purpose of the HIE is to allow the participating providers the benefit of having access to all of your health information that is maintained by participating providers when providing health care services to you. Your participation in the HIE is voluntary and you have previously elected to opt-out of the HIE.

By signing this form, I ACKNOWLEDGE and AGREE as follows:

- I previously exercised my right to opt-out of the HIE, but have changed my mind and would like to revoke my prior decision. **I would now like my health information to be shared through the HIE to all health care providers involved in my care who participate in the HIE.**
- I understand that by signing this form, that all of my health information from both before and after today's date will be shared through the HIE.
- I understand that my decision to permit my health information to be shared through the HIE may be cancelled again, at any time, by submitting a new completed DOH Health Information Exchange (HIE) Opt-Out Form at the location where I receive my DOH clinical services.
- It may take up to five (5) business days after receipt to process my request to permit that sharing of my health information through the HIE.

Last Name	First Name	Middle Name
Previous Name of Nickname	Date of Birth	Primary Phone Number
Address	City	State ZIP Code

If this form is signed by someone other than the person named above, the person signing the form certifies that they are acting as (check one) _____ Parent, _____ Legal Guardian, or _____Healthcare Power of Attorney for the person named above.

_____ _____

Printed Name Signature

_____

Date