CoxHealth
Health Information Exchanges

REVOCATION OF REQUEST TO OPT OUT

This form is to be used by patients who wish to **revoke** a prior Opt-Out form.

A Health Information Exchange (HIE) is a way of allowing your health information to be shared by participating medical groups, hospitals, labs, other health care providers, health plans, and other authorized users through secure, electronic means. The purpose of an HIE is to give your health care providers, health plan, and other authorized recipients the ability to efficiently access medical information necessary for your treatment, payment for your care, and other lawful purposes. Your participation in the HIE is voluntary and you previously exercised your right to opt-out of any HIEs in which CoxHealth participates.

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

1. I previously exercised my right to opt-out of HIE participation, but have changed my mind and would like to revoke my prior decision. I would now like my health information to be shared through any CoxHealth participating HIE to my health care providers, health plan, and other authorized recipients.
2. I understand that by signing this form all of my health information from both before and after today's date will be shared through any CoxHealth participating HIE.
3. I understand my decision to permit my health information to be shared may be cancelled again at any time by submitting a new completed "Opt-Out Form" to the address(es) provided at the bottom of that form.
4. It may take between **2 - 5 business days** after receipt to process my request to permit my health information to be shared.

First Name:____________________ Middle Name:____________________

Last Name:____________________ Previous Names or Nicknames:____________

Date of Birth:__________ Last 4 digits of SSN:______ Phone:____________

Address:____________ City:____________ State:_____ Zip:______

______________________________ ____________
Patient Signature (or Authorized Representative) Date Signed
Signature of parent, if under 18 years old, or Guardian

____________ ____________ ____________
Legal Representative Name Relationship to Patient Phone Number

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To Be Completed by a Notary Public

State of:__________ County of:__________ The foregoing instrument was acknowledged before me, a Notary Public, on ______ by ________________ (patient name), known to me to be the person whose name is subscribed to the within instrument, & acknowledged that he/she executed the same for the purposes therein contained. **Notary's signature:** ____________________

Instructions for Submission:

Mail: Midwest Health Connection
PMB 270
2000 East Broadway
Columbia MO 65201