Health Information Exchange Opt-Out Revocation Form

MR#:	*Patient Name: (please print)	*DOB: mm/dd/yyyy	*Facility:

A separate form must be completed by each family member wishing to Opt Out. Please complete all of the required fields for accurate processing. *Please print legibly* with a black ballpoint pen.

I hereby acknowledge and agree as follows:

1. I WISH TO REVOKE (change) my prior decision to Opt-Out of the SacValley Med-Share HIE, and now **specifically AUTHORIZE** my information maintained in the SacValley MedShare HIE to be electronically available to my providers;

2. I UNDERSTAND that by making this selection, now ALL of my authorized providers who participate in the SacValley MedShare HIE or are connected to the SacValley MedShare HIE will have access to my health information maintained in the SacValley MedShare HIE;

3. I UNDERSTAND that by making this selection, my health information may be accessible by other Connected HIEs with whom the SacValley MedShare HIE participates.

4. I UNDERSTAND that this Revocation can only be changed if I specifically submit a new HIE Opt-Out form;

5. I have had an opportunity to have all my questions regarding this "Revocation of Prior Opt-Out" and others answered;

6. This request can take **5 business days from receipt** to take effect. Please complete the next page, your request cannot be completed otherwise.

Fields marked with (*) are required fields for opt-out processing completion.

530-487-4997 info@sacvalleyms.org www.sacvalleyms.org
2485 Notre Dame Blvd. Suite 370-20 Chico, CA 95928

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Please print legibly. Social Security Number:	

*First Name	*Last Name	*DOB: mm/dd/yyyy

Mailing Address

Street Address	City	State	Zip

Telephone Number	Medical Record Number

*Sex: ☐ Male ☐ Female ☐ Other (check one box only)

Signature (Required): **Date:**

Print Authorized Representative's Name **Relationship to Patient**

_____ _____

Please Mail the Completed Form To:

SacValley MedShare, 2485 Notre Dame Blvd. Suite 370-20 Chico, CA 95928

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