

<Office/Clinic/Hospital Logo or Name>



Contexture Health Information Exchange (HIE) Opt-Out Request Form

I request that my health information not be viewable electronically through the Contexture Health Information Exchange (HIE) system. I acknowledge that my information may still be transmitted as necessary to provide clinical care and for other purposes as required by law. I also understand that by opting out, my health information will not be available through the HIE even in the case of an emergency. I understand this request only applies to viewing my health information through the health information exchange system. I recognize that when I see a physician for treatment outside of <this organization>, that physician may request and receive my medical information from <this organization> through other methods permitted by law, such as fax, mail, or courier. I am free to opt back in at any time and can do so by completing a *Contexture Opt-Back-In Request Form* that can be obtained from my healthcare provider.

A separate form must be filled out for each family member requesting to opt out.

Facility:	
Patient First Name:	
Patient Middle Name:	
Patient Last Name:	
Previous Names or Nicknames:	
Date of Birth: (mm / dd / yyyy)	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address:	
City, State, ZIP Code:	
Contact Phone Number:	

Signature of Patient
(Or Authorized Representative)
If under 18 years, signature of parent or guardian

Date

Please provide the completed form to:
Contexture
2000 S. Colorado Blvd.,
Denver, CO 80246