



## Contexture Health Information Exchange (HIE) Opt-Back-In Request Form

I previously submitted a request to “opt-out” of the Contexture health information exchange (HIE) system and am now requesting to be reinstated so that my health information can be electronically accessible to authorized health care providers through the HIE system.

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

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.,  
Tower 1, Ste. 12000  
Denver, CO 80222