

Health Information Exchange (HIE) Opt-Out Request Form

I do not want my health information shared through the Contexture HIE. I understand:

- My information may still be sent by fax, mail, or other legal methods if needed for treatment or required by law.
- If I see a doctor outside of **insert name of organization:** that provider might still receive my records by other means.
- In an emergency, doctors may not be able to access my health information through Contexture.
- I can change my decision anytime by submitting a Contexture Opt-In Request Form.
- Each family member must submit a separate form.
- I must sign and return this form to my health care provider.

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

Signature of Patient or Legal Representative

Check if signer is a Legal Representative

Date

Legal Representative Name (Print): _____

PROVIDER OFFICE: <u>PLEASE COMPLETE THIS BOX</u>
Facility/Provider:
Date:
Phone Number:
Please submit through a Contexture Help Desk Ticket or through secure fax at 720-285-3207.