

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

I previously submitted a request to “opt-out” of the Contexture HIE and am now requesting to be reinstated so that my health information can be electronically accessible to authorized health care providers through the HIE. This will include health information that was gathered before I sign this form. I understand:

- Each family member must submit a separate form.
- **All fields are required** for the form to be processed.
- **For my protection, Contexture requires that I return this form to my health care provider so that they may verify my identity.**

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

Date

Check if signer is a Legal Representative

Legal Representative Name (Print): _____

<p>PROVIDER OFFICE ONLY: <u>PLEASE COMPLETE THIS BOX</u></p> <p>Facility/Provider: Date: Phone Number:</p> <p style="text-align: center; margin-top: 20px;">Please submit through a Contexture Help Desk Ticket or through secure fax at 720-285-3207.</p>
