Midwest Health Connection Revocation of Opt-Out Form

This form is to be used by patients who wish to **revoke** a prior opt-out form.

Midwest Health Connection health information exchange (MHC HIE) is a way of allowing your health information to be shared by participating medical groups, hospitals, labs, other health care providers, health plans, and other authorized users through secure, electronic means. The purpose of the MHC HIE is to give your healthcare providers, health plan and other authorized recipients the ability to efficiently access medical information necessary for your treatment, payment for your care and other lawful purposes. Your participation in the HIE is voluntary and you previously exercised your right to opt-out of the MHC HIE.

By signing this form, I hereby ACKNOWLEDGE and AGREE as follows:

1. I previously exercised my right to opt-out of the MHC HIE, but have changed my mind and would like to revoke my prior decision. I would now like my health information to be shared through the MHC HIE to my health care providers, health plan, and other authorized recipients who participate in or are connected to the MHC HIE.

2. I understand that by signing this form all of my health information from both before and after today's date will be shared through the MHC HIE.

3. I understand that my decision to permit my health information to be shared through the MHC HIE may be cancelled again at any time by submitting a new completed "Opt-Out Form" to the address provided at the bottom of that form.

4. It may take between **2-5 business days after receipt** to process my request to permit my health information to be shared through the MHC HIE.

Patient's Name: Last *	First*	Middle Initial
Previous Name or Nicknames:	Patient's Date of Birth:*	Primary Phone Number: * ( ) -
Postal Address:*	City:*	State:*
Zip:*	Last 4 of SSN:*	Patient Access Representative:

*Required information

_____ _____

Signature of Patient (or Authorized Representative) Date Signed

If under 18 years, signature of Parent or Guardian

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_____	_____	_____
Legal Representative Name *	Relationship to Patient*	Phone Number *

This area is to be completed by a Notary Public

The foregoing instrument was acknowledged before me, a Notary Public, on _____ (date) by _____ (patient name), known to me to be the person whose name is subscribed to the within instrument and acknowledged that he/she executed the same for the purposes therein contained.

Notary Signature: _____State: _____ County: _____
Notary Stamp:

Submission Instructions:
Mail To:

Midwest Health Connection
PMB 270
2000 East Broadway
Columbia MO 65201