Provider Location:

REVOKE OPT-OUT FORM

I previously submitted a request to "opt out" of PHIX Health Information Exchange System and am now requesting to be reinstated so that my health care information can be electronically accessible to authorized health care providers through the PHIX system.

- A separate form must be filled out for each family member who previously opted out and is now requesting to revoke that opt out
- ALL FIELDS ARE REQUIRED for form to be processed
- Contact phone number is required in case PHIX needs to contact you to ensure accuracy of your demographic information

____

Patient Last Name ***First Name*** ***Middle Initial*** ***(Previous Names/Nicknames)***

____

Mailing Address ***City*** ***State*** ***Zip Code***

( ) -
____

Contact Phone Number ***Social Security # (Last 4 digits)*** ***Date of Birth (mm/dd/yyyy)***

_______________________________________ _______________________________________

Signature of Patient Date Signed

_______________________________________ _______________________________________

Signature of Parent/Guardian Date Signed

_______________________________________ _______________________________________

Parent/Guardian Name Parent/Guardian Contact Telephone

☐ Parent ☐ Guardian ☐ Other____

Section to be completed by a Notary Public or HealthCare Provider (or PHIX staff):

I witnessed the above named individual signing this document and the individual is personally known to me or provided me with valid picture identification on this day ____________________________________of__________, 20_____

Notary or Provider
Signature:____ Phone Number:___________________

Print Name:____ Date Signed:______________________

(Must be original signature in black or blue ink)

PRACTICE ADMINISTRATOR: Please send the completed form via fax to 844-833-6810.