CoxHealth
Health Information Exchanges

REQUEST TO OPT OUT

I understand EACH of the following statements:

I am signing this form because I do NOT want my health records shared with my doctors and health care team members through any Health Information Exchanges (HIEs) in which CoxHealth participates.

Signing this request means that my doctors and caregivers will NOT be able to see my electronic health records through an HIE, even in an emergency.

This "Request to Opt Out" cancels any written consent to share my health records with HIEs I completed before this date; however, my health care team is not required to remove any of my health records shared before this date.

First Name: ______________________ Middle Name: ______________________

Last Name: ______________________ Previous Names or Nicknames: ______________

Date of Birth: ______________ Email: ______________________ Last 4 digits of SSN: __________

Street Address: ____

City: ______________ State: ________ Zip: __________ Phone: ______________

____ ______________________

Patient/Guardian/Legal Representative Signature Date:

To Be Completed by a Notary Public

State of: ______________ County of: ______________ The foregoing instrument was acknowledged before me, a Notary Public, on __________ by ______________________ (patient name), known to me to be the person whose name is subscribed to the within instrument, & acknowledged that he/she executed the same for the purposes therein contained. **Notary's signature:** ______________________

Instructions for Submission:

Mail: Midwest Health Connection
PMB 270
2000 East Broadway
Columbia MO 65201