SACVALLEY MEDSHARE

The Health Information Exchange for California's North Central Valley

Opt-Out Revocation Form

MR#: _____ **Patient Name:** _____ **DOB:** _____

I hereby acknowledge and agree as follows:

1. I WISH TO REVOKE (change) my prior decision to Opt-Out of the SacValley MedShare HIE, and now **specifically AUTHORIZE** my information maintained in the SacValley MedShare HIE to be electronically available to my providers;

2. I UNDERSTAND that by making this selection, now ALL of my authorized providers who participate in the SacValley MedShare HIE or are connected to the SacValley MedShare HIE will have access to my health information maintained in the SacValley MedShare HIE;

3. I UNDERSTAND that by making this selection, my health information may be accessible by other Connected HIEs with whom the SacValley MedShare HIE participates.

4. I UNDERSTAND that this Revocation can only be changed if I specifically submit a new HIE Opt-Out form;

5. I have had an opportunity to have all my questions regarding this "Revocation of Prior Opt-Out" and others answered;

6. This request can take **5 business days from receipt** to take effect.

Please complete the next page, your request cannot be completed otherwise.

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MR#: _____ **Patient Name:** _____ **DOB:** _____

_____ _____

Patient Name DOB

_____

Address, City, State, Zip

_____ _____

Phone Number Fax Phone Number

_____

Signature Date

_____

Patient Representative Relationship to Patient

Please send completed form to:

SacValley MedShare, 1448 Esplanade, Chico CA 95926