



SACVALLEY MEDSHARE

The Health Information Exchange
for California's North Central Valley
P.O. Box 9217
Chico, CA 95927-9217

Health Information Exchange Opt-Out Revocation Form

*This area is to be completed by office staff. An asterisk (*) indicates required information.*

* **Clinic, Facility or Organization Name:**

MR#:

* **Patient Name:** (please print)

* **DOB:** (mm/dd/yyyy)

Patient Statement

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. Your request will be processed within 10 business days of receipt by the SVMS mailroom. **Confirmation will be mailed to the address listed on this form.** If you have not received a confirmation notice within 30 days please contact us at info@sacvalleymys.org.

Please fill out the next page to complete your Opt-Out Revocation Request.



SACVALLEY MEDSHARE

The Health Information Exchange
for California's North Central Valley
P.O. Box 9217
Chico, CA 95927-9217

Health Information Exchange Opt-Out Revocation Form

This area is to be completed by the patient.

Please print legibly. Asterisk (*) indicates required information.

*** Clinic, Facility, or Organization Name:**

*** First Name:**

*** Last Name:**

*** DOB:** (mm/dd/yyyy)

Social Security Number:

Telephone Number:

Sex: Male Female Other (check one box only)

Mailing Address (Street Address, City, State, Zip Code):

*** Signature:**

*** Date:**

*** Print Authorized Representative's Name**

*** Relationship to Patient**

SVMS must be able to confirm the validity of "Authorized Representative" status through the Clinic, Facility, or Organization listed on this form.

Please Mail To: **SacValley MedShare, PO Box 9217, Chico CA 95927-9217**