INTEGRIS HEALTH

Revocation of Opt-Out of INTEGRIS Health Information Exchange (HIE)

Patient Last Name	Patient First Name			Date of Birth
Address	**City**	**State**	**Zip**	**Telephone Number**

I wish to **REVOKE** or rescind my **HIE OPT-OUT request**.

I understand by making this selection my health care information will be exchanged/viewed through the HIE network(s) in which INTEGRIS Health is participating.

Additional Information regarding this Revocation of Opt-Out Request

1. This request will remain in effect unless you change it in writing by completing the Opt-Out of INTEGRIS Health Information Exchange form.
2. This request may include health information from visits during the period in which you were opted out.
3. This Opt-Out revocation will be effective approximately 5-7 business days following the receipt by INTEGRIS Health and will remain effective until I choose to opt back out.

_____	_____	
Name of Patient or Legal Representative (PRINT)	Relationship to Patient/Authority to Act on Patient's Behalf	
_____	_____	_____
Signature of Patient or Legal Representative	Date	Time

The completed form may be faxed to **INTEGRIS Health Information Management** at 405-552-8773, mailed to 3433 NW 56th Street, Bld. B Ste. C50 Oklahoma City, OK 73112, or emailed to Healthinfomanagement@integrishealth.org. For questions, call 877-778-7211.

Patient Label
Patient Name:
MRN:
DOB: