



## CORHIO Health Information Exchange (HIE) Opt-Out Request Form

I request that my health information not be viewable through the CORHIO (Colorado Regional Health Information Organization) health information exchange (HIE) system.

Please initial that you have read and understand each the following statements.

\_\_\_\_\_ I understand that by submitting this *HIE Opt-Out Request Form* my health information will not be viewable by health care providers (including emergency room physicians) through the CORHIO HIE system.

\_\_\_\_\_ I hereby request that CORHIO to block access to my health information through the CORHIO HIE system.

\_\_\_\_\_ I understand that I am free to opt back in at any time and can do so by completing a CORHIO *Health Information Exchange (HIE) Opt-In Request Form* that can be obtained from CORHIO's website at [www.corhio.org](http://www.corhio.org) or from my health care provider.

I understand this request only applies to sharing my health information through the CORHIO HIE system. I recognize that when I see a health care provider for treatment that provider may request and receive my medical information from other providers using other methods permitted by law, such as fax or mail.

(A separate form must be filled out for each family member requesting to opt out. **All fields are required** for form to be processed. Contact Phone Number is required in case CORHIO needs to contact you to ensure accuracy of demographic information.)

|                                     |                             |                                       |
|-------------------------------------|-----------------------------|---------------------------------------|
| <b>Patient First Name:</b>          | <b>Patient Middle Name:</b> | <b>Patient Last Name:</b>             |
| <b>Previous Names or Nicknames:</b> |                             | <b>Date of Birth (mm / dd / yyyy)</b> |
| <b>Mailing Address:</b>             |                             | <b>City, State, Zip Code:</b>         |
| <b>Contact Phone Number:</b>        |                             |                                       |

\_\_\_\_\_  
**Signature of Patient** (or Authorized Representative)

\_\_\_\_\_  
**Date Signed**

If under 18 years, signature of parent or guardian

**For your protection, CORHIO requires that you verify your identity in order to process this Request. This form must be completed by a Notary Public.**

**This form must be returned by mail to CORHIO with original signatures in black or blue ink.**

----- Section below to be completed by a Notary Public -----

State of \_\_\_\_\_

County of \_\_\_\_\_

The foregoing instrument was acknowledged before me this \_\_\_\_\_ by \_\_\_\_\_  
(date) (name of person acknowledged)

Notary Print Name: \_\_\_\_\_

Notary Signature: \_\_\_\_\_

|               |
|---------------|
| Notary Stamp: |
|---------------|

Please mail this form to: CORHIO, Attn.: Service Desk – HIE Request, 3773 Cherry Creek North Drive, Suite 615, Denver, CO 80209