Provider Location:

PdNHIE REVOKE OPT-OUT FORM

Paso del Norte Health Information Exchange

I previously submitted a request to "opt out" of PdNHIE Health Information Exchange System and am now requesting to be reinstated so that my health care information can be electronically accessible to authorized health care providers through the PdNHIE system.

- A separate form must be filled out for each family member who previously opted out and is now requesting to revoke that opt out.
- ALL FIELDS ARE REQUIRED for form to be processed.
- Contact phone number is required in case PdNHIE needs to contact you to ensure accuracy of your demographic information.

Patient Last Name ***First Name*** ***Middle Initial*** ***(Previous Names/Nicknames)***

Mailing Address ***City,*** ***State*** ***Zip Code***

( ) -
Contact Phone Number ***Social Security # (Last 4 digits)*** ***Date of Birth (mm/dd/yyyy)***

Signature of Patient Date Signed

Signature of Parent/Guardian Date Signed
If patient under 18 years, signature of patient guardian

Parent/Guardian Name Parent/Guardian Contact Telephone

☐ Parent ☐ Guardian ☐ Other________________________________

Section to be completed by a Notary Public or Health Care Provider (or office staff):

I witnessed the above named individual signing this document and the individual is personally known to me or provided me with valid picture identification on this day ____of________, 20___

Notary or Provider Signature: ________________________________ Phone Number: _

Print Name: Date Signed:

(Must be original signature in black or blue ink)

PRACTICE ADMINISTRATOR: Please send the completed form via PdNHIE DIRECT to "PdNHIE consent forms-sent here" (searchable in Location tab) or fax to 915-xxx-xxxx