MISSOURI HEALTH CONNECTION

May 2017

Request to Opt Out

I do not want to share my health records.

Please read and understand each of the following statements:

- Signing this request means that my doctors and caregivers will NOT be able to see my electronic health records through Missouri Health Connection (MHC), even in an emergency.
- This “Request to Opt Out” cancels any written consent to share my health records with MHC that I completed before this date; however, my health care team is not required to remove any of my health records that were shared with them before this date.
- I may choose to join MHC again at any time by signing an “Authorization and Consent” form.
- I am signing this form because I do not want my health records shared with my doctors and health care team members through Missouri Health Connection (MHC).

Patient Information:

First Name:______________________________ Last Name: ______________________________

Middle Name:______________________________ Other Name: ______________________________

Birth Date:______________________________ Gender: ______________________________

Phone:______________________________ Social: ______________________________

Address: ____ City:

State:__Zip:__________Email Address: ______________

____

Patient Signature:

X ____ Date: ____________________

This area is to be completed by a Notary Public

The foregoing instrument was acknowledged before me, a Notary Public, on______________(date) by____(patient name), known to me to be the person whose name is subscribed to the within instrument & acknowledged that he/she executed the same for the purposes therein contained.

Notary Signature: __________________ State: ___ County: __________________

Submission Instructions:	Notary Stamp:
Mail To: Missouri Health Connection PMB 270 2000 East Broadway Columbia MO 65201	