To opt into the HIE, complete this form and return it to your provider.

Please print clearly.

Name: ____
Last First Middle

Are you known by any other names? If yes, please list.

____

Date of birth: ____

Social Security Number____

Address: ____

Phone: ____

Opt in: I do want my health information to be included in the HIE. I have read and fully understand the information provided to me regarding the Provider HIE and opting in.

____
Signature of Patient or Authorized Representative

____
Name of Authorized Representative

____
Address of Authorized Representative

____
Date

*Please allow up to five (5) business days for your information to be included back in the system.