Request to Opt-Out

September 2020

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 Midwest Health Connection (MHC), even in the event of 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 Midwest Health Connection (MHC).
- It may take 2-5 business days after receipt, to process this Opt-Out form and to prevent the sharing of my health information through the MHC HIE.

Patient Information:

First Name:_____ Last Name: _____

Middle Name:_____ Other Name: _____

Birth Date:_____ Gender:_____

Phone:_____ Social:_____

Address:_____

City:_____ State:_____ Zip: _____

Email Address: _____

PatientSignature:

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

Notary Signature:_____ State:____ County: _____

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