HEALTH INFORMATION EXCHANGE - REVOKE OPT OUT REQUEST FORM

I previously submitted a request to "Opt Out" of the Ventura County Health Care Agency (VCHCA) Health Information Exchange (HIE). I now request that I be reinstated, so that my health information may be electronically accessed through the HIE network by authorized health care providers.

Patient's Name: _____
Last: First: Middle:

Previous Name or Nicknames: _____ **Patient's Date of Birth:** _____ **Sex (M/F):** _____

Address: _____
Street City State ZIP

Primary Phone Number:(_____)_____

_____ _____
Signature **Date Signed**

If signed by someone other than the patient, please print name below and indicate relationship.

_____
Representative Name **Representative Relationship to Patient** **Representative Phone #**

Return form to VCHCA:
Email: HIEconnect@ventura.org

Mail: Ventura County Health Care Agency
c/o: HIM Dept.
300 Hillmont Avenue, Ventura, CA 93003