

# PATIENT OPT-OUT

As of December 19, 2013



Patient Name	Date of Birth	Date Form Signed
Patient Address: Street, City, State, Zip Code		
Telephone Number	Cell Phone Number	Email

OPT-OUT. I elect to OPT-OUT of One Health Record. I do not wish to participate in One Health Record. I understand my health information and/or records will not be shared through One Health Record.

\_\_\_\_\_  
**Signature of Patient or  
Authorized Representative**

\_\_\_\_\_  
Printed Name of Health Care  
Provider/Facility where signed  
and NPI# \_\_\_\_\_

\_\_\_\_\_  
Date

Authorized Representative

Print name of Authorized Representative: \_\_\_\_\_

Authority to sign on behalf of patient (e.g., health care power of attorney, guardian, parent of minor): \_\_\_\_\_

If the Patient or Authorized Representative does not sign this *Opt-Out form* at a health care provider's facility or office, then the signature of the Patient or Authorized Representative must be notarized below.

\_\_\_\_\_  
Notary Public

\_\_\_\_\_  
Date of Expiration  
of Commission

\_\_\_\_\_  
Date Notarized

Please complete this form, sign, and submit originals to:

\_\_\_\_\_