Return to MyHealth Access Network Request Form

To revoke your previously-submitted request to opt out of MyHealth Access Network, please initial that you have read and understand the following:

_____ By submitting this form, I am choosing to reverse my earlier decision to opt out. I am choosing to allow for my health information to *be disclosed* to healthcare workers through the MyHealth Access Network system.

MyHealth Access Network is a secure local health information exchange network, operated by an Oklahoma non-profit organization under the direction of its members. We help healthcare workers in Oklahoma to efficiently, privately and securely disclose health information to each other about the patients they have in common to improve the quality and efficiency of services. MyHealth Access Network also helps healthcare workers with essential business operations, including public health reporting and postmortem investigations. Only those whose jobs require this type of information are authorized to receive limited disclosures, all of which are tracked. Misuse of the system is a crime, punishable with severe penalties. The network rules are set by the members of the network.

A separate form must be submitted for each person requesting to opt back in. Please complete the form using the same information you have provided to your doctors. A phone number is required in case we need to contact you to coordinate fulfillment of your request. Requests are processed upon receipt, in any case within one business day. This form requires identity verification either 1) by submitting it to a healthcare provider who is part of MyHealth, who can validate the request and immediately submit the form for processing; or 2) by signing in the presence of a notary public, and having it notarized, then delivering it to MyHealth directly. If submitting to MyHealth directly, and the requestor is an emancipated minor or utilizes a healthcare proxy, please include documentation of the signor's authority.

Patient First Name:	**Patient Middle Name:**	**Patient Last Name:**
Previous Names or Nicknames:	**Date of Birth (mm / dd / yyyy):**	
Mailing Address:	**Last 4 digits of Social Security Number:**	
City, State, Zip Code:		
Contact Phone Number:		

Deliver to a MyHealth-participating provider, OR notarize and mail to:

MyHealth Access Network
ATTN: Opt Out
PO Box 56,
Tulsa, OK 74101

_____ _____
Signature of Patient / Authorized Representative **Date Signed**
(for Authorized Representative, please print name beside signature)

Identity Verification

MyHealth Provider

_____ _____
Signature: Witness Name, Position, and MyHealth Participant Organization

Notary Public OR

State of_____ County of _____
The foregoing instrument was acknowledged before me on

_____ by_____.
(Date) (Name of person acknowledged)

Notary Signature: _____ Name: _____

Notary Stamp

Form last modified October 2023