MyHealth Access Network Opt-Out Request Form

This form is to be completed in front of and submitted to your health care provider, who must sign below.

I request that my health information *not* be viewable through the MyHealth Access Network (MyHealth).

Please initial that you have read and understand each the following statements.

_____ I request and understand that by submitting this Opt-Out Request Form, my health information will *not* be viewable by health care providers through MyHealth except in emergency situations.

_____ I understand that I am free to opt back in at any time and can do so by completing a Return to MyHealth Request Form that can be obtained at MyHealth's website at http://myhealthaccess.net/opt-in or from my health care provider.

I understand this request only applies to sharing my health information through the MyHealth system. I recognize that when I see a health care provider for treatment, that provider may request and receive my medical information from other providers using other methods permitted by law, such as fax, mail, secure messaging, or other means.

(A separate form must be filled out for each family member requesting to opt out. **All fields are required** for form to be processed. A contact phone number is required in case MyHealth needs to contact you to ensure accuracy of demographic information.)

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		

For your protection, MYHEALTH REQUIRES THAT YOU VERIFY YOUR IDENTITY to process this Request.

_____ _____

Signature of Patient (or Authorized Representative) **Date Signed**
If under 18 years, signature of parent or guardian

_____ _____

Organization Rep Signature as Witness Position and Name of Organization

If you cannot complete this in person with your health care provider,
you may have this form notarized and mail it to:
MyHealth Access Network, ATTN: Opt Out, P.O. Box 56, Tulsa, OK 74101

---------- **Notary Public Section** ----------

State of_____ County of _____

The foregoing instrument was acknowledged before me this _____ by_____.
(Date) (Name of person acknowledged)

Notary Print Name: _____

Notary Signature: _____

Notary Stamp