



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 for my health information to *be made viewable* for 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 share health information with 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 for limited access, all of which is 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.

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|-------------------------------------|-----------------------------|---|
| 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: | | Deliver to a MyHealth-participating provider, OR notarize and mail to: MyHealth Access Network ATTN: Opt Out PO Box 56, Tulsa, OK 74101 |
| Contact Phone Number: | | |

Signature of Patient / Authorized Representative
(for Authorized Representative, please print name beside signature)

Date Signed

| | | | |
|------------------------------|--------------------------|---|--|
| 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: _____ | |

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| Notary Stamp |
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