healthcurrent

Opt Back In Form

Please complete and return this form to your healthcare provider who will return this form to Health Current.

Use this "Opt Back In Form" to change an earlier decision to opt out of securely sharing your health information through Health Current, Arizona's health information exchange (HIE). If you previously completed and returned an "Opt Out Form" and want to cancel that decision, please sign and give this form to your healthcare provider. If you are filling out this form for another person, the references to "I" and "my" in this form refer to that other person.

Patient Name:_____ **Date of Birth**: _____

Street Address:_____

City:_____ **State**:_____ **Zip**:_____

Decision to Opt Back In. I want to change an earlier decision to opt out of having my health information shared through Health Current. I understand that by signing this form I agree to have my health information securely shared through Health Current. This will include health information that was gathered before I sign this form.

Signature of Patient or Patient's Parent/Guardian/Healthcare Decision Maker:_____

Print Name:_____ **Date**:_____

If signed by a person other than the patient, please indicate your authority to sign for the patient (check one):

☐ Spouse ☐ Parent/Guardian ☐ Caregiver with authority to make healthcare decisions

If you are signing on behalf of more than one patient (such as your children) to change an earlier decision to opt out, please fill out a separate "Opt Back In Form" for each patient.

Provider Office Only: This section must be completed before sending via secure fax to Health Current.

Organization/Provider: _____

Print Name:_____ Date:_____

Signature:_____ Phone:_____