ICARE SYSTEM REVOCATION OF OPT-OUT FORM

I previously submitted a request to "Opt-Out" of the Connxus Health Information Exchange, known as the ICare System, by signing an ICare System Opt-Out Form. I am now requesting to be reinstated in the ICare System so that my Protected Health Information ("PHI") can be electronically shared with my healthcare providers, plans and payors who participate in the ICare System ("Participants") through the ICare System.

[ ] By signing this ICare System Revocation of Opt-Out Form, I agree to have my PHI shared, used and disclosed electronically with the Connxus and Participants in the ICare System.

A separate form must be filled out for each family member who previously signed an ICare System Opt-Out Form and is now requesting to revoke that Opt-Out decision by completing this ICare System Revocation of Opt-Out Form.

_____

Patient Name

_____

Mailing Address City State Zip Code

(___)_____-_____

Contact Phone Number Last 4 digits of Social Security # Date of Birth

_____

Signature of Patient Date Signed

_____

Signature of Legally Authorized Representative [ ] Parent [ ] Guardian [ ] Other

Provider Location: _____

Practice Administrator: Please send the completed Revocation of Opt-Out Form to Connxus, ATTN: Office Manager, 1401 Lavaca St. PMB 40115, Austin, TX 78701, or scan and send to info@connxus.org. **Patient ICare System Opt-out Form** **Patient ICare System Opt-out Form**