



OPT OUT FORM

When complete, please send this form to:

Iowa Health Information Network
4601 Westown Parkway, Suite 140
West Des Moines, IA 50266

Legal Name:		Date of Birth:	Gender:
Mailing Address:	City:	State:	Zip:
Last Four Digits of Social Security Number OR Driver's License Number:			
Primary Phone Number:		Cell Phone Number:	
Maiden/Previous Names:		Email Address:	
Patient or Legal Representative:			Date:
_____ X _____ (Print) (Signature)			
Relationship, if not patient*:			

Please indicate your reason for opting out of allowing your electronic health records to be searchable through the Iowa Health Information Network (IHIN):

- Concerns about security of data provided through IHIN
- Concerns about validity of data provided through IHIN
- Other _____

Iowa e-Health will process your request within three business days of receiving this form. Questions? Contact Iowa e-Health at info@IHIN.org or 866-924-4636.

*Submit documentation of status of legal representative; e.g., health care power of attorney.