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:
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: _____ X_____ (Print) (Signature)			Date:
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 Health Information Network 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.