VITL

Vermont Health Information Exchange
Revocation of Opt-Out Form

If you have previously opted out of sharing your health information via the Vermont Information Health Exchange, but now want healthcare professionals involved in your care to see your health information, please fill out this form.

_____ _____

Full Name (First Middle Last, Suffix) Date of Birth (mm/dd/yyyy)

_____

Physical Address (Street, Apt/Unit, City, State, Zip)

_____ _____

Primary Phone Number (Including area code) Secondary Phone Number (Including area code)

_____

Email Address (In case we need to reach out when processing this form)

_____

Name(s) of hospital(s), practice(s), and other Health Care Organization(s) you have visited in the past ten years. This will be used to help with patient matching.

_____

_____

Would you like to receive confirmation once your revoke opt-out request has been completed?
Yes, please contact me by: ☐ Phone ☐ Email ☐ No need to contact me ☐ Other: _____
We will use the information you provided above to send the confirmation.

By signing below, I choose to Revoke Opt-Out – please show my records in the Vermont Health Information Exchange to Health Care Organizations involved in my care.

I understand that falsifying my identity or signing on behalf of an individual in which I do not have authority is against the law and punishable offense. For more information on signature requirements, please contact VITL directly.

_____ _____

Signature of Patient (If patient is 12 years old or older) Date

_____ _____

Signature of Parent or Authorized Representative Date

- If patient is younger than 12 years old, signature of Parent or Authorized Representative is required
- If patient is between 12-18 years old, signature of Parent or Authorized Representative is optional

_____ _____

Name of Parent or Authorized Representative Relationship to Patient

Once completed, please mail to VITL:
Vermont Information Technology Leaders (VITL)
150 Dorset Street, Suite 245, PMB 358
South Burlington, VT 05403
Questions? Call VITL toll free at 1-888-980-1234 or visit https://vthealthInfo.com

Verification by Notary Public

Instructions for Notary Public: Before signing below, examine government photo ID to verify identity of Patient or Authorized Representative.

STATE OF _____

COUNTY OF _____, ss.

At _____, this _____ day of _____, _____ personally appeared, and s/he acknowledged this instrument by him sealed and subscribed, to be his/her free act and deed.

Before me, _____
Notary Public

My Commission Expires: _____
Date

Questions? Call VITL toll free at 1-888-980-1234 or visit https://vthealthInfo.com