I, _____, (*print name of patient or resident*) having previously submitted a "Request for Restrictions on Access to Health Information through Electronic Health Information Exchange" (KHIE Opt-Out), hereby authorize _____, (*print name of organization*) its employees and providers to access, use or disclose my health information found on the Kansas Health Information Exchange ("KHIE").

This authorization applies only to this encounter and does not constitute a revocation of my Request for Restrictions on Access. I acknowledge that I must contact KHIE if I want to formally request a revocation of my Request for Restrictions on Access.

_____am/pm

Signature of Patient/Patient Representative Date Time

_____

Relationship to Patient

This form is included as a permanent part of the patient/resident medical record for the encounter for which it was completed.

PATIENT OR RESIDENT AUTHORIZATION TO ACCESS RESTRICTED HEALTH INFORMATION THROUGH THE KANSAS HEALTH INFORMATION EXCHANGE
VC3977 1/13

PATIENT IDENTIFICATION