



## 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.

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 or fax to VITL:  
Vermont Information Technology Leaders (VITL)  
150 Dorset Street  
Suite 245, PMB 358  
Burlington, VT 05403**

**Questions? Call VITL toll free at 1-888-980-1234 or visit <https://vthealthinfo.com>**

## Verification by Notary Public

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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