Vermont Health Information Exchange
Opt-Out Form

If you do not 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 Opt-Out – please hide my records in the Vermont Health Information Exchange from 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