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 1-888-980-1243 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