



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 1-888-980-1243 or visit <https://vthealthInfo.com>