OPT-OUT FORM

To learn about the consequences of opting out of the Iowa Health Information Network (IHIN), please speak to your health care provider. You can also refer to the "YOUR HEALTH RECORDS, YOUR CHOICE" brochure, which has additional instructions on preparing this form. If you do not have a brochure, please visit www.IowaeHealth.org and click on "Patient."

When complete, please send this form to:
Iowa e-Health
321 E 12th Street
Des Moines, Iowa 50319
Fax: 515-281-4958

Legal Name:			Date of Birth:
Mailing Address:	City:	State:	Zip:
Last Four Digits of Social Security Number OR Driver's License Number:			
Primary Phone Number:	Cell Phone Number:		
Maiden/Previous Names:	Email Address:		
Patient or Legal Representative: _____ X _____ (Print) (Signature)			Date:
Relationship, if not patient*:			

Please indicate your reason for opting out of allowing your electronic health records to be searchable through the Iowa Health Information Network (IHIN):

- ☐ Concerns about security of data provided through IHIN
- ☐ Concerns about validity of data provided through IHIN
- ☐ Other _____

Iowa e-Health will process your request within three business days of receiving this form.

Questions? Contact Iowa e-Health at ehealth@idph.iowa.gov or 866-924-4636.

*Submit documentation of status of legal representative; e.g., health care power of attorney.

IHIN
Iowa Health
Information Network

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