Rappahannock Health Connect
Revocation of Opt-Out Form

I have previously decided to opt-out of Rappahannock Health Connect (RHC) and have decided to reverse that decision. I understand that by making this decision, my medical information will become available only to those who are authorized to view my information through RHC.

I hereby acknowledge and agree as follows:

1. I WISH TO REVOKE (change) my prior decision to Opt-Out of RHC, and now I **specifically AUTHORIZE** my past, present and future information maintained in RHC to be electronically available to authorized participants;

2. I understand that by making this selection now, all of my providers and insurers who participate in or are connected to RHC will have access to my health information available through RHC for appropriate purposes;

3. I understand that this Revocation can only be changed if I specifically submit a new RHC Opt-Out form, which is available at [URL]; and

4. This request will be processed promptly upon receipt by RHC. RHC's goal is to process all Opt-Out Revocations within 7 days.

Patient Name_____ M /F Date of Birth_____/_____/_____
Last First Middle Initial Gender (circle) (MM/DD/YYYY)

Address: _____ Phone #:_____
Street City State Zip Code

Signature_____ Date of Signature_____/_____/_____
Patient or Legal Representative (MM/DD/YYYY)

If Legal Representative – Printed Name: _____ Relationship to Patient_____

If you would like to receive an email confirming that your opt-out has been processed, please provide us with your email address where this confirmation can be sent: _____.

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All completed Opt-Out forms should be sent to the EMPI Administrator for RHC. Please submit the completed Opt-Out form to RHC as follows:

B y Facsimile: (540) 741-3239	By Mail: 1201B Sam Perry Boulevard, Suite 210, Fredericksburg, VA 22401

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RHC MWHC