

Dear Patient:

If you previously submitted an Opt-Out Request form for the Reliance eHealth Collaborative and would now like to participate again in Reliance, please complete the attached Opt-Out Cancellation form.

By submitting a Cancellation form, authorized health care providers will be able to search for your test results and medical information through Reliance. This includes any test or other medical information that was generated while you were not participating.

For your protection, your identity must be verified in one of three ways: have this form signed by a Notary Public or by a licensed Health Care Provider or their designee, or present a valid government-issued photo identification to staff at the Reliance office.

If you have any questions, please contact Reliance by phone: (855) 290-5443, email support@RelianceHIE.org, or visit the website at www.RelianceHIE.org.

Reliance is Good for You and Your Doctor:

Reliance is a faster and more secure way for health care providers such as doctors, hospitals, labs, and x-ray facilities to share patient health information. Reliance is not a complete record of your health history. It is a way for health care providers to quickly get the medical information they need to provide you with better care.

- Reliance is a **secure** way for your doctors to get the most up-to-date medical information about you. Only those caring for you will be allowed to see your test results and other medical information. In a medical emergency, information that could help save your life will be available to emergency doctors at participating hospitals.
- Reliance **improves care** by sending results to your doctor quickly and securely. Reliance can also help your doctors refer you to specialist so that you can get an appointment faster.
- Reliance **saves you time and money**. If a specialist needs you to have tests done before your visit, your doctor can send you for the tests *before* you go to the specialist(s). Because your doctor will have this information before you come in for your appointment, you won't have to repeat tests or carry medical records with you to appointments.
- Reliance **protects privacy** by having security safeguards and standards in place to protect your information. Your doctors can send information to other doctors without using phone calls, mailing or faxing, and only the correct, authorized health care staff will see your information. Reliance can also track who has looked at your information—making your health information more secure.

Thank you for choosing to participate in Reliance!

Opt-Out Cancellation Form for the Reliance eHealth Collaborative



Please initial that you have read and understand each of the following statements.

I previously chose to opt-out and not to participate in Reliance by completing an Opt-Out Request form.

Initial _____

I understand that by submitting this *Cancellation Request Form* authorized participating health care providers will now be able to search for my medical information through Reliance.

Initial _____

I hereby authorize Reliance to cancel my previous request to opt-out.

Initial _____

First Name: _____ Middle Name: _____ Last Name: _____

Previous/Maiden Last Name: _____ Date of Birth: _____ (Ex: 01/01/1990) Gender: Female Male

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone 1: _____ Phone 2: _____

Email Address: _____ Last Four (4) Digits of Social Security Number: _____ (Ex. xxx-xx-1234)

Patient Signature or Legal Rep.: X Date Signed: _____
(If under age 18 years, signature of parent or legal guardian)

For your protection, we must verify your identity in order for Reliance to process the *Cancellation Request*.

Your identity may be verified one of three ways: have this form signed by a Notary Public or by a licensed Health Care Provider or their designee, or present a valid government-issued photo identification to staff at the Reliance office.

This form must be submitted to Reliance with original signatures in black or blue ink.

Section to be completed by a Notary Public or Licensed Health Care Provider or their designee:

I witnessed the above named individual (or their legal representative) sign this document and the individual is personally known to me and/or provided me with valid picture identification on this day ____ of _____, 20____.
Year Day Month

Notary or Provider
Print Name: _____ Phone Number: _____

Notary or Provider
Signature: X Date Signed: _____

Must be an original signature in black or blue ink.