CyncHealth IOWA

Health Information Exchange (HIE) Opt-In Request Form

I previously submitted a request to "opt-out" of the CyncHealth Health Information Exchange (HIE) system and am now requesting to be reinstated so that my health information can be electronically accessible to authorized healthcare providers through the CyncHealth HIE system.

- A separate form must be filled out for each family member requesting to opt back in.
- **All fields are required** for the form to be processed.
- Contact phone number is required in case CyncHealth needs to contact you to ensure accuracy of demographic information.

Patient's Last Name:	Patient's First Name:		Middle Initial:
Previous Name or Nicknames:	Patient's Date of Birth:	Primary Phone Number:	
Postal Address:	City:	State: Zip:	

For your protection, CyncHealth requires that you verify your identity in order to process this request. This form must be completed by a Notary Public. This form must be returned by mail to CyncHealth with original signatures in black or blue ink.

Signature of Patient:
_____Date:_____

If the patient is under 18 years, the Signature of the Parent or Guardian is required below:

Signature of Parent or Guardian: _____
Relationship to Patient: _____
Date:_____

-------- -------- -------- -------- Section below to be completed by a Notary Public -------- -------- -------- --------

State of _____ County of _____

The foregoing instrument was acknowledged before me this _____ by _____.
(date) (name of person acknowledged)

Notary Print Name: _____

Notary Signature: _____

Notary Stamp:

Email the completed notarized form to support@cynchealth.org
Or mail this completed form to:
CyncHealth Privacy Office
P.O. Box 27842
Omaha, NE 68127