WELLPORT

Health Information Exchange

Request to Withdraw Permission to Share Health Information

I have previously given permission for my health care providers to release information to create a Clinical Health Summary and Personal Health Summary in Wellport. By signing this form, I am requesting that my health information no longer be included in Wellport.

Some information to know and acknowledge:

- Opting out will take effect within no more than three (3) business days (M-F) after Wellport receives and acknowledges written notice.
- Information recorded in any provider's own Electronic Health Records cannot be removed as this constitutes the provider's medical record.

I wish to withdraw my permission (opt out) so that **all** of my Wellport providers will no longer release my health information to create a Clinical Health Summary and a Personal Health Summary in Wellport. All information previously added to the health summary will be retained but will no longer be viewable.

_____
Name of Patient (Print)

_____
Signature of patient or patient's personal representative

_____
Relationship of signatory to patient (if not patient)

_____
Date

_____
Patient Date of Birth

Address: _____
Street

_____ _____ _____
City or Town State Zip