NEW MEXICO HEALTH INFORMATION COLLABORATIVE (NMHIC)
HEALTH INFORMATION EXCHANGE (HIE) NETWORK

Do you need more information?
Email us at: info@nmhic.org
Or call 505-938-9900

Opt-Out
Complete and mail or fax the form below. Address and fax number are the end of this form.

Opt-Back In
Complete and mail or fax the form below. Address and fax number are the end of this form.

You have a choice and can change your mind at any time.

Example – Decide to Opt-out: If you fill out this form and mail or fax it in, the NMHIC HIE system will not allow access to any of your current or past medical information reported to the Health Information Exchange under any circumstances, including an emergency situation. If you change your mind later and would like to reverse your decision you can **Opt-Back In** at any time.

I Choose to Opt-Out ☐ **I Choose to Opt-Back In** ☐

After you have made your selection by checking one of the boxes above, fill out this form and mail to the address below.

Note: If you are under 18 years of age, a parent or legal guardian must sign below. A decision to Opt-Out remains in effect until the minor turns 18, at which time the individual is responsible for making his or her own decision.

*Patient Last Name: _____ *Suffix (if applicable, e.g., Jr.): _____

*First Name: _____ *Middle Name or Initial: _____

*Patient Date of Birth: (mm/dd/yyyy): _____ Last 4 digits of SS#: _____

*Home Address: _____

*City: _____ *State: _____ *Zip Code: _____

*Home Phone #: _____ Business Phone #: _____

Email Address: _____ *Gender (Male/Female): _____

** Signifies a required field*

When I have chosen to **Opt-Out** and sign and mail in this form, I understand that I am choosing for my health information not to be accessible in the NMHIC Health Information Exchange network to anyone under any circumstances.

When I have chosen to **Opt-Back In** and sign and mail this form, I understand that I am choosing for my health information to be available in the NMHIC Health Information Exchange network to authorized users who have obtained my written consent.

_____ *Date: _____
*Signature of Patient or Authorized Representative

☐ Check here if signing as parent, guardian, or authorized representative and print name and authority:

_____ *Date: _____
*Printed Name of Parent/Guardian & relationship to patient

Fax form to 505-938-9940, or mail to:
New Mexico Health Information Collaborative HIE, 2309 Renard Pl. SE, Suite 103, Albuquerque, NM 87106