Mid-Atlantic States

HEALTH INFORMATION EXCHANGE OPT IN REQUEST FORM

Original: 07/26/2013 Revised: 7/9/2020

MR #: ____________________

Name: ____________________

Sex/.BD: ____________________

I previously submitted a request to "Opt-Out" of having my information shared electronically by Kaiser Permanente Mid-Atlantic States (KP MAS) and now request that I be reinstated so that my health information can be electronically accessed through an HIE network by authorized health care providers.

A separate form must be completed by each family member wishing to Opt-In. Please complete all of the below required fields for accurate processing.

Patient Name *(print)*	**Health Record #**	**Date of Birth**	**Mailing Address**	**Telephone #**

X Signature (Required) ____________________ **Date** ___ | ___ | _____

If signed by someone other than the patient, please print name below and indicate relationship. Submit documents to show authority.

____________________ ____________________

Print Authorized Representative's Name Relationship to patient

Once this form is complete, please return to:

FAX: 855-889-3320 or EMAIL: MASHIEOPT@kp.org

For Kaiser Use Only:

1. Print Staff Name: ____________________
2. Dept: ____________________ Ph#: ____________________
3. Date Received: ____ | ____ | _______

NS-11375 (06-20)