KAISER PERMANENTE® *HAWAII REGION*

Health Information Exchange Opt IN Request Form

Original: 07/31/13 Revised:

MR#:

Name:

Sex/.BD:

I previously submitted a request to "Opt-Out" of all Kaiser Permanente Health Information Exchanges (HIE) 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. Print legibly with a black ball point pen.

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 mail to:

Kaiser Permanente
Patient Identity Administration
501 Alakawa Street
Honolulu, HI 96817

For Kaiser Use Only:

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

Patient ID Use Only:

Staff Name:

Date Implemented:

White: MRA- Patient ID / Dole