TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER™
EL PASO

Health Information Exchange
REVOCATION of OPT-OUT

I previously submitted a request to "opt out" of PHIX and/or data inoperability system/Health Information Exchange. I am now requesting to be reinstated so that my health care information can be electronically accessible to authorized health care providers through the PHIX and/or data interoperability/HIE system.

- A separate form must be filled out for each family member who is requesting to revoke the opt out.
- ALL FIELDS ARE REQUIRED for the form to be processed.
- A principal Contact Telephone Number is required in case you need to be contacted to ensure accuracy of your demographic information.

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Patient Last Name ***First Name*** ***Middle Initial*** ***(Previous Names/Nicknames)***

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Mailing Address ***City*** ***State*** ***Zip Code***

( ) -
____
Principal Contact Telephone Number ***Date of Birth (mm/dd/yyyy)***

___________________________________ ___________________________________
Signature of Patient Date Signed

___________________________________ ___________________________________
Signature of Parent/Guardian Date Signed

___________________________________ ___________________________________
Parent/Guardian Name (Print Name) Parent/Guardian Principal Contact Telephone Number

☐ Parent ☐ Guardian ☐ Other______________________________

Section to be completed by a TTUHSC staff:
I witnessed the above named individual signing this document and the individual is personally known to me or provided me with valid picture identification on this day__of_________, 20____.

TTUHSC Witness
Signature: ____ Phone Number: ___________________

Print Name:____ _ Date Signed: ______________________

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