



CORHIO Health Information Exchange (HIE) Opt-In Request Form

I previously submitted a request to “opt-out” of the CORHIO Health Information Exchange (HIE) system and am now requesting to be reinstated so that my health information can be electronically accessible to authorized health care providers through the CORHIO HIE system.

- A separate form must be filled out for each family member requesting to opt back in.
- **All fields are required** for the form to be processed.
- Contact phone number is required in case CORHIO needs to contact you to ensure accuracy of demographic information.

Patient First Name:	
Patient Middle Name:	
Patient Last Name:	
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Previous Name(s) or Nickname(s):	
Date of Birth (mm/dd/yyyy):	
Street Address:	
City, State, Zip Code:	
Phone Number:	

Signature of Patient (or Authorized Representative)

Date Signed

If under 18 years, signature of parent or guardian

**For your protection, CORHIO requires that you verify your identity in order to process this request.
 This form must be completed by a Notary Public.**

This form must be returned by mail to CORHIO with original signatures in black or blue ink.

----- Section below to be completed by a Notary Public -----

State of _____ County of _____

The foregoing instrument was acknowledged before me this _____ by _____.
 (date) (name of person acknowledged)

Notary Print Name: _____

Notary Signature: _____

Mail this form to:

CORHIO, Attn.: Service Desk – HIE Request
 4500 Cherry Creek S Drive, Suite 820
 Denver, CO 80246

Notary Stamp: