SHRINERS HOSPITALS FOR CHILDREN®
OPT-IN CANCELLATION REQUEST
FOR THE SHC HIE

Please initial that you have read and understand each of the following statements.

_____ I previously chose to opt-in and participate in SHC HIE.
Initial

_____ I understand that by submitting this *Cancellation Request* authorized participating healthcare providers will not be able to search for my medical information through SHC HIE.
Initial

_____ I hereby authorize SHC HIE to cancel my previous request to opt-in.
Initial

_____ I request that all my medical information be deleted from the SHC HIE, **OR**
Initial

_____ Any medical information currently on the SHC HIE may remain.
Initial

Patient's Name: Last*	First*	Middle Initial
Previous Name or Nicknames:	Patient's Date of Birth:*	Primary Phone Number:* ( ) -
Email:	Sex (M/F):	Secondary Phone Number: ( ) -
Address:*	City:*	State:* Zip:*

*required information

I hereby authorize Shriners Hospitals for Children® to cancel disclosure to:

Physician's Name:*		
Address:*	City:*	State:* Zip:*
Email:		Phone Number: ( ) -

*required information

Patient Signature
or Legal Representative: _____ **Date:** _____ **Time:** _____
(If under age 18 years, signature of parent or legal guardian)

Witness Signature: _____ **Date:** _____ **Time:** _____

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Shriners Hospitals for Children®

* H I E 2 *

Patient Information Label