



Request to Withdraw Permission to Share Health Information

I have previously given permission for some or all of my health care providers to release information to create a Shared Health Summary that is part of Wellport. By signing this form, I am requesting that my health information no longer be included in the Shared Health Summary (opt-out).

Some information to know and acknowledge:

- Opting out will take effect within no more than three (3) business days (M-F) after your written notice is received and acknowledged by the practice or hospital.
- Information recorded in any provider's own Electronic Health Records cannot be removed as this constitutes the provider's medical record.

I wish to withdraw my permission (opt out) so that from this day forward the undersigned hospital or practice will no longer release information to create a Shared Health Summary that is part of Wellport. Any information previously added to the Shared Health Summary by this hospital or practice will be retained but will no longer be viewable.

I wish to withdraw my permission (opt out) so that **all** of my Wellport providers from this day forward will no longer release information to create a Shared Health Summary that is part of Wellport. All information previously added to the health summary will be retained but will no longer be viewable.

Name of Patient (Print)

Signature of patient or patient's personal representative

Relationship of signatory to patient (if not patient)

Date

Patient Date of Birth

Name of Provider Receiving this Form (Practice Name or Hospital)

Provider Representative Signature

Date of Provider Representative Signature