Request to Rescind the Restriction of Disclosure of Health Information

By signing this form, you are revoking your Request to Restrict Disclosure of Health Information, previously signed, and granting permission for your health information or your minor child's health information be made available through IHDE.

Please mail or fax this form to the address or fax number below. Keep a copy of this form for your records.

☐ I wish to revoke my request to restrict disclosure of my health information and make it available to participants in the Idaho Health Data Exchange.

(Please Print Legal Name)

Patient First Name	Middle Initial	Last Name	
Other names you have used (maiden name, etc)			
Street Address			
City		State	Zip Code
Phone Number	Date of Birth (MM/DD/YYYY)	Gender ☐ M ☐ F	Last 4 digits of patient's social security number
Parent/Guardian/Personal Representative Name (Please print)			Relationship to Patient
Patient or Parent/Guardian Signature			Date

State of Idaho)
S.S.
County of _____)

On this ____day of _____, in the year of 20____, before me _____, personally appeared _____, proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument, and acknowledged that he (she) executed the same.

_____
Notary Public

My Commission Expires on _____

Mail to: Idaho Health Data Exchange
P.O. Box 6978
Boise, ID 83707

FAX to: 208-803-0031
Attn: Idaho Health Data Exchange