



Request to Rescind Restrict 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 <input type="checkbox"/> M <input type="checkbox"/> 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: 208-332-7217
Attn: Idaho Health Data Exchange