



Request to Restrict Disclosure of Health Information

The IHDE allows participating providers to access health information about you so you can get the best possible medical care. It will provide access to your health information in an emergency when you might not be able to answer questions. Making this information available at the point of care can help reduce medical errors.

You can choose whether to make your health information available to providers participating in the IHDE. The medication history available through the IHDE may indicate the presence of a substance abuse issue, mental health condition, and other condition that you may consider sensitive. If you do not want this information to be shared through IHDE, you should make a request to restrict the disclosure of your health information. If you request a restriction, only your name, date of birth and gender will be available to participating providers. However, the benefits of making your medical information accessible to providers who are caring for you will not be available to you.

If you decide you do not want your health information or your minor child's health information made available through the IHDE, mail or fax this form to the address or fax number below. Keep a copy of this form for your records. You will receive a letter confirming your request. If you decide later that you want to make your health information available through IHDE, you must complete a request to rescind form to withdraw your request.

I do not want my health information made available to participants in the Idaho Health Data Exchange.

I do not want my child's health information made available to participants in the Idaho Health Data Exchange.

(Please print)

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

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

Fax to: 208-334-6558
Attn: Idaho Health Data Exchange