the Chickasaw Nation
Department of Health
1921 Stonecipher Boulevard / Ada, OK 74820 / (580) 436-3980

Bill Anoatubby
Governor

Patient Identification

Health Information Exchange/Data Sharing Opt-out Request

This opt-out form is for two separate data sharing requests. Please read the form thoroughly and note the following before completing your request.

**Each patient making a request to opt-out must use a separate form.*
**All fields are required for your request to be processed. (Exception, you do not have to opt-out of both networks if you do not wish to do so.)*
**A Chickasaw Nation Department of Health (CNDH) member may contact you if further information is needed.*
**For your protection, CNDH MUST VERIFY YOUR IDENTITY, or that of a parent/legal guardian or authorized representative, to process your request.*

Care Everywhere Network (Epic):

_____ (initials) I understand that by submitting this opt-out request, my health information will **NOT** be viewable by health care providers through the Epic system. I request that my health information not be shared with non-CNDH providers.

_____ (initials) I understand that I can opt-in to the Epic system at any time by completing an opt-in request that can be obtained from the CNDH Website at www.chickasawnationhealth.net or by emailing CNDHCareEverywhereHelp@chickasaw.net or by calling (580) 276-1806.

_____ (initials) I understand this request only applies to sharing my health information through the Epic system. I recognize that when I see a health care provider for treatment, that provider may request and receive my health information from other providers using other methods permitted by law, such as fax, mail, secure messaging or other means.

MyHealth Access Network (Oklahoma HIE):

_____ (initials) I understand that by submitting this opt-out request, my health information will **NOT** be viewable by health care providers, Chickasaw Nation or any other outside providers through the MyHealth system.

_____ (initials) I understand that I can opt-in to the MyHealth system at any time by completing an opt-in request that can be obtained from the CNDH website at www.chickasawnationhealth.net or by emailing CNDHCareEverywhereHelp@chickasaw.net or by calling (580) 276-1806.

_____ (initials) I understand this request only applies to sharing my health information through the MyHealth system. I recognize that when I see a health care provider for treatment, that provider may request and receive my health information from other providers using other methods permitted by law, such as fax, mail, secure messaging or other means.

Patient name: _____
First Middle Last Suffix

Patient birth date: _____ (mm/dd/yyyy) Patient last 4 of Social Security No.: _____

Patient mailing address: _____
Street City State ZIP

Patient physical address: _____
Street City State ZIP

Patient phone no.: (___) _____

_____ _____
Patient/authorized representative signature (if patient is under 18 years of age.) Date/time

_____
CNDH representative printed name

_____ _____
CNDH representative signature as witness Date/time