

OPT-BACK-IN FORM

Use this form only if you previously opted out of the Iowa Health Information Network. For instructions on preparing this form, please refer to the "YOUR HEALTH RECORDS, YOUR CHOICE" brochure. If you do not have a brochure, please visit www.lowaeHealth.org and click on "Patient."

When complete, please send this form to:

Iowa e-Health
321 E 12th Street
Des Moines, Iowa 50319
Fax: 515-281-4958

Legal Name:		Date of Birth:	
Mailing Address:	City:	State:	Zip:
Last Four Digits of Social Security Number OR Driver's License Number:			
Primary Phone Number:	Cell Phone Number:		
Maiden/Previous Names:	Email Address:		
Patient or Legal Representative:		Date:	
_____ X _____ (Print) (Signature)			
Relationship, if not patient*:			
Signature of Notary:		Date:	

Iowa e-Health will process your request within three business days of receiving this form.

Questions? Contact Iowa e-Health at ehhealth@idph.iowa.gov or 866-924-4636.

*Submit documentation of status of legal representative; e.g., health care power of attorney.



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