Non-Participation Request Form

What is MS-HIN?

The Mississippi Health Information Network (MS-HIN) provides a fast and secure way for doctors and hospitals to share certain types of health information, such as lab results and x-ray reports. MS-HIN is not a complete medical record. It is a simple way for authorized health care providers to access patient medical information, allowing them to provide you with the best care possible.

How Does MS-HIN Help You and Your Doctor?

MS-HIN Is Fast and Secure

MS-HIN is a fast and secure way for your doctor to locate your most up-to-date medical information. Only health care providers with a valid reason will be allowed to access your medical information. Information will be available to emergency room (ER) health care providers that could help save your life in a medical emergency. MS-HIN also helps safeguard your medical information in the case of an emergency like a fire or natural disaster.

MS-HIN Protects Privacy

MS-HIN protects your privacy better than paper records by tracking who has looked at your information. A report of who has accessed your medical information is available from MS-HIN.

MS-HIN Improves Your Care

MS-HIN allows your doctor to have immediate access to a variety of medical information. This information can help your doctor make better decisions about your care. Accessing lost records through MS-HIN may also prevent your doctor from having you repeat tests; potentially saving you time and money.

Non-Participation in MS-HIN:

Patients who do not want their medical information to be accessible to authorized health care providers through MS-HIN may choose not to participate. If you choose not to participate, health care providers will not be able to access your health information. This means your health information will be unavailable to emergency personnel, even during life-threatening emergencies.

If you do not want to participate in MS-HIN, please complete this Non-Participation Form and submit it to MS-HIN with original signatures via mail or email to:

Mississippi Health Information Network
805 South Wheatley
Suite 540
Ridgeland, Mississippi 39157

If you have any questions, or for more information, please contact MS-HIN at 601-977-8192 or email Info@ms-hin.ms.gov.

MS HIN
MISSISSIPPI HEALTH INFORMATION NETWORK

Non-Participation Request Form

Please initial that you have read and understand each of the following statements:

Initials: _____ I understand that not participating in MS-HIN means my medical information will not be accessible to health care providers, including emergency personnel, through a query of MS-HIN.

Initials: _____ I hereby authorize MS-HIN to block query access to my medical information in MSCHIE.

Initials: _____ I understand that I may choose to participate in MS-HIN again at any time by submitting a Reinstatement of Participation Form.

Please provide all of the following information:

First Name: _____ Middle Name: _____ Last Name: _____

Previous Last Name: _____ Date of Birth: _____ (Ex: 01/01/1990) Gender: ☐ Female ☐ Male

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone 1: _____ Phone 2: _____

Email Address: _____ Last Four (4) Digits of Social Security Number: _____

Patient Signature: _____ **Date:** _____
(If under 18 years of age, signature of parent or legal guardian)

For your protection, MS-HIN must verify your identity before processing this Non-Participation Request. Your identify may be verified one of two ways: have this form signed by a Notary Public OR by a Health Care Provider (physician, nurse practitioner or physician's assistant) licensed in Mississippi.

Please return this completed form to MS-HIN with original signatures in black or blue ink.

This section must be completed by a Licensed Health Care Provider (MD, DO, NP, PA) or Notary Public:

I witnessed the above named individual sign this document and the individual is personally known to me or provided me with valid picture identification on this, the _____day of _____, 20 _____.

Printed Name: _____ Phone: ( ) _____

Signature: X _____ Date: _____

Must be an original signature in black or blue ink.

Reinstatement of Participation Request

What is MS-HIN?

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MS-HIN is a fast and secure way for your doctor to locate your most up-to-date medical information. Only health care providers with a valid reason will be allowed to access your medical information. Information will be available to emergency room health care providers that could help save your life in a medical emergency. MS-HIN also helps safeguard your medical information in the case of an emergency like a fire or natural disaster.

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MS-HIN protects your privacy better than paper records by tracking who has looked at your information. A report of who has accessed your medical information is available from MS-HIN.

MS-HIN Improves Your Care

MS-HIN allows your doctor to have immediate access to a variety of medical information. This information can help your doctor make better decisions about your care. Accessing lost records through MS-HIN may also prevent your doctor from having you repeat tests; potentially saving you time and money.

Instructions for Completing a Reinstatement of Participation Request:

If you wish to reinstate you participation in MS-HIN, please complete the following Reinstatement Form and submit it with original signatures via mail or email to:

Mississippi Health Information Network
805 South Wheatley
Suite 540
Ridgeland, Mississippi 39157

If you have any questions, or for more information, please contact MS-HIN at 601-977-8192 or email Info@ms-hin.ms.gov.

MS-HIN
MISSISSIPPI Health Information Network

Reinstatement of Participation Request

Please initial that you have read and understand each of the following statements:

Initials: _____ I have previously chosen not to participate in MS-HIN and completed/submitted a Non-Participation Request Form.

Initials: _____ I understand that by submitting this Reinstatement Request, my medical information will be accessible to authorized health care providers through MS-HIN.

Initials: _____ I authorize MS-HIN to cancel my previous request for non-participation.

Please provide all of the following information:

First Name: _____ Middle Name: _____ Last Name: _____

Previous Last Name: _____ Date of Birth: _____ (Ex: 01/01/1990) Gender: ☐ Female ☐ Male

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone 1: _____ Phone 2: _____

Email Address: _____ Last Four (4) Digits of Social Security Number: _____

Patient Signature: _____ **Date:** _____
(If under 18 years of age, signature of parent or legal guardian)

For your protection, MS-HIN must verify your identity before processing this reinstatement request.
Your identify may be verified one of two ways: have this form signed by a Notary Public OR by a Health Care Provider (physician, nurse practitioner or physician's assistant) licensed in Mississippi.

Please return this completed form to MS-HIN with original signatures in black or blue ink.

This section must be completed by a Licensed Health Care Provider (MD, DO, NP, PA) or Notary Public:

I witnessed the above named individual sign this document and the individual is personally known to me or provided me with valid picture identification on this, the _____day of _____, 20 _____.

Printed Name: _____ Phone: ( ) _____

Signature: X _____ Date: _____

Must be an original signature in black or blue ink.