

## South Dakota Health Link Health Information Exchange (HIE) Opt-Out Request Form

I request that my health information not be viewable through the South Dakota Health Link (SDHL) HIE system.

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

\_\_\_\_\_ I understand that by submitting this HIE *Opt-Out Request Form* my health information will not be viewable by health care providers (including emergency room physicians) through the SDHL HIE system.

\_\_\_\_\_ I hereby request that SDHL block access to my health information through the SDHL HIE system.

\_\_\_\_\_ I understand that I am free to opt back in at any time and can do so by completing a South Dakota Health Link *HIE Opt-In Request Form* that can be obtained from South Dakota Health Link's website at [www.sdhealthlink.org](http://www.sdhealthlink.org), or requesting a copy from SDHL at the address at the bottom of the page.

I understand this request only applies to sharing my health information through the SDHL HIE system. I recognize that when I see a health care provider for treatment that provider may request and receive my medical information from other providers using other methods permitted by law, such as fax or mail.

(A separate form must be filled out for each family member requesting to opt out. **All fields are required** for form to be processed. Contact Phone Number is required in case SD Health Link needs to contact you to ensure accuracy of demographic information.)

<b>Patient First Name:</b>	<b>Patient Middle Name:</b>	<b>Patient Last Name:</b>
<b>Previous Names or Nicknames:</b>		<b>Date of Birth (mm / dd / yyyy)</b>
<b>Mailing Address:</b>		<b>City, State, Zip Code:</b>
<b>Contact Phone Number:</b>		

\_\_\_\_\_  
**Signature of Patient** (or Authorized Representative)  
 If under 18 years, signature of parent or guardian

\_\_\_\_\_  
**Date Signed**

**For your protection, SDHL requires that you verify your identity in order to process this Request.  
 The section below must be completed by a Notary Public or your Physician.**

**This form must be returned by mail to SDHL with original signatures in black or blue ink.**

----- Section below to be completed by a Notary Public or Physician -----

State of \_\_\_\_\_ County of \_\_\_\_\_

The foregoing instrument was acknowledged before me this \_\_\_\_\_ by \_\_\_\_\_.  
 (date) (name of person acknowledged)

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_  
 Physician or Notary

Notary Stamp if verified by Notary:

Please mail this form to: SD Health Link, Attn.: Opt-Out Processing,  
 820 N Washington Ave, Madison, SD 57042