Request to Rescind the Restriction of Disclosure of Health Information

By signing this form, you are revoking your Request to Restrict Disclosure of Health Information, previously signed, and granting permission for your health information or your minor child's health information be made available through IHDE.

Please mail or fax this form to the address or fax number below. Keep a copy of this form for your records.

☐ I wish to revoke my request to restrict disclosure of my health information and make it available to participants in the Idaho Health Data Exchange.

(Please Print Legal Name)

Patient First Name	Middle Initial	Last Name	
Other names you have used (maiden name, etc)			
Street Address			
City		State	Zip Code
Phone Number		Email	
Date of Birth (MM/DD/YYYY)		Gender ☐ M ☐ 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 190983
Boise, ID 83719

Fax to: 208-803-0031

Request to Restrict Disclosure of Health Information

You may want to consider the benefits of having your health information available through the Idaho Health Data Exchange (IHDE) before submitting this form. The IHDE is a Health Information Exchange (HIE) with the mission of improving the coordination and quality of health care across Idaho.
Health information in the IHDE provides healthcare providers and medical staff with a quick snapshot of your current and past health to make more informed decisions about your care. This is valuable in an emergency situation if you might not be able to communicate. Having this information quickly available also helps to reduce medical errors and duplicate tests.

Only IHDE participants have secure access to your medical records in the IHDE. These participants may ONLY access data for purposes of treatment, payment, and healthcare operations which promote efficiency of communication in care, patient safety, and enhance patient health. These participants also have to abide by the IHDE programs and policies which include HIPAA privacy and security standards. Use of the IHDE system for any other reason is strictly prohibited.

You can choose whether to make your health information available to providers participating in the IHDE. If you request a restriction, also known as "Opting Out", only your name, date of birth and gender will be available to participating providers.

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 (opt back in) 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/guardian child's health information made available to participants in the Idaho Health Data Exchange. *(Minors will automatically be opted back in to the exchange upon turning 18)

(Please print)

Patient Legal First Name	Middle Initial	Last Name	
Other names you have used (maiden name, etc.)			
Street Address			
City		State	Zip Code
Phone Number		Email	
Date of Birth (MM/DD/YYYY)		Gender ☐ M ☐ 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

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