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

Chris Anoatubby
Governor

Patient Identification

Health Information Exchange/Data Sharing Opt-In Request

This opt-in 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-in must use a separate form.*
**All fields are required for your request to be processed. (Exception: you do not have to opt-in to 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):

_____ (initial) I revoke my request to opt-out and understand that my submitting this opt-in request, my health information (past, present and future) **WILL** be viewable by health care providers through the Epic system.

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

_____ (initial) I understand this request only applies to sharing my health information through the Epic system.

MyHealth Access Network (Oklahoma HIE):

_____ (initial) I revoke my request to opt-out and understand that my submitting this opt-in request, my health information (past, present and future) **WILL** be viewable by health care providers through **MyHealth**.

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

_____ (initial) I understand this request only applies to sharing my health information through the MyHealth system.

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