MyHealth ACCESS NETWORK

Return to MyHealth Access Network Request Form

This form is to be completed in front of and submitted to your health care provider, who must sign below.

I request to revoke my previous request to opt out, and hereby request that my health information *will* be viewable through the MyHealth Access Network (MyHealth).

Please initial that you have read and understand the following statement:

_____ I request and understand that by submitting this Return Request Form, my health information *will* be viewable to my health care providers through MyHealth.

(A separate form must be filled out for each family member requesting to revoke a previous opt-out request. **All fields are required** for form to be processed. A contact phone number is required in case MyHealth needs to contact you to ensure accuracy of demographic information.)

Patient First Name:	**Patient Middle Name:**	**Patient Last Name:**
Previous Names or Nicknames:	**Date of Birth (mm / dd / yyyy)**	
Mailing Address:	**Last 4 digits of Social Security Number:**	
City, State, Zip Code:		
Contact Phone Number		

For your protection, MYHEALTH REQUIRES THAT YOU VERIFY YOUR IDENTITY to process this Request.

_____ _____

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

_____ _____

Organization Rep Signature as Witness Position and Name of Organization

If you cannot complete this in person with your health care provider,
you may have this form notarized and mail it to:
MyHealth Access Network, ATTN: Opt Out, P.O. Box 56, Tulsa, OK 74101

---------- **Notary Public Section** ----------

State of_____ County of _____

The foregoing instrument was acknowledged before me this _____ by_____.
(Date) (Name of person acknowledged)

Notary Print Name: _____

Notary Signature: _____

Notary Stamp