Contexture/CORHIO Health Information Exchange (HIE)

I previously submitted a request to "opt-out" of the Contexture/CORHIO Health Information Exchange (HIE) system and am now requesting to be reinstated so that my health information can be electronically accessible to authorized health care providers through the HIE system.

A separate form must be filled out for each family member requesting to opt back in.

Facility:	
Patient First Name:	
Patient Middle Name:	
Patient Last Name:	
Previous Names or Nicknames:	
Date of Birth:	(mm / dd / yyyy)
Gender	____ Male ____ Female
Mailing Address:	
City, State, ZIP Code:	
Contact Phone Number:	

_____   _____

Signature of Patient   (or authorized representative)   **Date/Time**
If under 18 years, signature of parent or guardian

Please provide the completed form to:

CORHIO
4500 Cherry Creek Dr. South, Suite #820
Denver, CO 80246
Fax-720-285-3207

Patient Label

HIPAA Patient Request _CC

CORHIO Opt-Back-In Request Form   HIP 038E 1022