South Dakota Health Link Point of Care Exchange (PoC) Opt-In Request Form

I request that my previous Opt-Out request be rescinded, and that my health information be viewable through the South Dakota Health Link (SDHL) PoC system.

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

_____ I understand that by submitting this PoC *Opt-In Request Form* my health information *will* be viewable by health care providers (including emergency room physicians) through the SDHL PoC system.

_____ I hereby request that SDHL allow access to my health information through the SDHL PoC system.

_____ I understand that I am free to opt back out at any time and can do so by completing a South Dakota Health Link *PoC Opt-Out Request Form* that can be obtained from South Dakota Health Link's website at 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 PoC system from the date I signed this Opt-In form and forward.

(A separate form must be filled out for each family member requesting to opt in. **All fields are required** for the form to be processed.)

Patient First Name:	**Patient Middle Name:**	**Patient Last Name:**
Gender:		**Date of Birth (mm / dd / yyyy)**
Mailing Address:		
City, State, Zip Code:		**Contact Phone Number:**

_____ _____

Signature of Patient (or Authorized Representative) **Date Signed**

If under 18 years, signature of parent or guardian

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 _____ (date) by _____ (name of person acknowledged).

Print Name: _____

Notary Stamp if verified by Notary:

Signature: _____
Physician or Notary

Notary Commission Expiration: _____

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