Participation Change Request

Great Lakes Health Connect

This form allows you to limit electronic access of your health information. The HIPAA Privacy Rule permits the use and disclosure of Protected Health Information for purposes of treatment, payment, and operations. Great Lakes Health Connect (GLHC) is an electronic health information exchange service which your treating providers use to share health information about you. Your health information will be available electronically to your treating providers unless you decide to ***opt out*** and not have your information shared electronically. Even if you decide to ***opt out*** of data exchange via GLHC some legally permissible identifiable health information will still be transferred electronically.

If you ***opt out***, your treating providers will not be able to access your health information by making an electronic inquiry through GLHC, ***even*** in the case of an emergency. You have the option to change your mind and reverse your opt out decision. You have a right to a copy of this form.

If you sign as a legal representative, all references in this form refer to the patient.

Instructions: Check ***only one*** box and ***print all of the requested information below***. Please sign and date the form.

☐ Request to ***OPT OUT***: I do not want my authorized health care providers to access my health information by making an electronic inquiry through GLHC.

OR

☐ Request to ***reverse*** previous opt out decision: I want to reverse my previous decision to opt out and allow my health information accessible to my authorized health care providers through GLHC, unless restricted by applicable state or federal laws.

ALL FIELDS ARE REQUIRED UNLESS NOTED AS "OPTIONAL"

First Name _____ Middle Name _____ Last Name _____

Previous Last Name (optional) _____ Date of Birth _____/_____/_____ Gender M F
(MM/DD/YYYY) (Circle one)

Street Address _____

City _____ State _____ Zip Code _____

Telephone (_____) _____ Cell /Alternate Phone (optional) (_____) _____

Legal Representative (if applicable) _____ Relationship to Patient _____

Patient or Legal Representative Signature _____ Date Signed _____/_____/_____
(If under the age of 18, signature of parent or legal guardian) (MM/DD/YYYY)

Reason, if other than patient: ☐ Patient is incapacitated
☐ Patient is a minor

This section MUST be completed by your Health Care Provider (MD, DO, NP, PA)

Name of Health Care Provider _____ Phone (_____) _____

Address _____ Fax (_____) _____

PLEASE FAX TO GLHC THE SAME DAY: (616) 588-4710

Request completed by GLHC _____/_____/_____ (MM/DD/YYYY) Rev: 041515