Participation Change Request

Great Lakes Health Connect (GLHC) is a non-profit organization that helps healthcare providers enhance care and reduce costs. This form instructs GLHC to change an individual's participation status.

Under Michigan law, healthcare organizations can collect, store, and share patient information electronically for treatment, payment, and operational reasons. Michigan law permits citizens to opt out of having their health records shared through Great Lakes Health Connect. GLHC is required to show and share health record when state and federal laws require it.

Step 1: Select a participation status.

	Request to OPT OUT - I do not want my health records in the GLHC community health record (unless the law requires it).
	Request to OPT IN - I previously opted out, but now wish my health records to be included in the GLHC community health record (unless the law prevents it).

Step 2: Demographic Information
All fields are required, unless noted as "optional". All references below refer to the patient. A legal representative may complete this form for a patient who is incapacitated or is a minor (under 18).

Full Name (First Middle Last)	Date of Birth	
Previous Last Name (optional)	Gender Male Female	
Street Address		
City	State	Zip Code
Phone	Alternate Phone (optional)	
Signature (Patient or Legal Representative)	Date	
Legal Representative Name (Print)	Relationship to Patient	
If signed by Legal Representative of the patient, select a reason. Patient is incapacitated Patient is a minor (under 18 years old)		

Step 3: Identity verification
GLHC requires identity verification to protect patients. A Notary Public OR a healthcare provider must verify the patient's identity. Please indicate who is verifying the patients identity.

	Notary Public - The completed and notarized form must be MAILED to GLHC with original signatures in black or blue ink. Great Lakes Health Connect Attn: Participation Change Request 695 Kenmoor Ave SE, Suite B Grand Rapids, MI 49546
	Healthcare provider - The completed form must be returned to GLHC via secure email: support@gl-hc.org.

The Notary Public OR the Healthcare provider must complete the section below.

I witnessed the above named individual sign the document and the individual is personally known to me or provided me with valid picture identification on this day,

__________________ *(month)* _________ *(day number),* _________ *(year).*

Name (print)	Phone Number
Signature	Date

(844) 454.2443
gl-hc.org
info@gl-hc.org