DIGESTIVE HEALTH ASSOCIATES
PROFESSIONAL CORPORATION

CORHIO Health Information Exchange (HIE) Opt-In Request Form

I previously submitted a request to "opt-out" of the 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 CORHIO 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)
If under 18 years, signature of parent or guardian

Signature Date

Please provide the completed form to:
Digestive Health Associates
2 Burnett Court, Suite 100
Durango, CO 81301

Phone: 970-385-4022
Fax: 970-385-4337