Instructions for Cancellation of a Non-Participation Request:

You previously submitted a request for non-participation in DHIN and would now like to begin participating again. Please complete the attached *Cancellation Request* form.

By submitting a *Cancellation Request*, your test results and medical information will be accessible to authorized health care providers through DHIN.

For your protection, DHIN requires that you verify your identity in one of two ways: have the form signed by a health care provider licensed in Delaware, or have the form signed by a notary public.

Thank you for choosing to participate in DHIN!

The Delaware Health Information Network (DHIN) provides fast and secure exchange of test results and reports among hospitals, labs, x-ray facilities and doctors statewide. DHIN is *not* a complete record of your health history. It is simply a way for health care providers to access patient medical information that they need to provide you with the best care possible.

DHIN is Good for You and Your Doctor.

- DHIN is a **secure** way for your doctor to get the most up-to-date medical information about you. Only health care providers with a valid reason will be allowed to see your test results and reports. Also, information that could help save your life in a medical emergency will be available to emergency room (ER) doctors.

- DHIN **improves care** by sending results to your doctor quickly and safely as soon as they are ready. DHIN also makes sure your results and records are safe in case of an emergency like a fire or flood.

- DHIN **protects privacy** by tracking who has looked at your information. A report of who has looked at your medical information is available from DHIN. Your health information is not available to health insurance companies or your employer through DHIN.

Cancellation of a Non-Participation Request

for the Delaware Health Information Network

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

_____ I have previously chosen not to participate in DHIN and completed a *Request for Non-Participation* form.
Initial

_____ I understand that by submitting this *Cancellation Request* that my test results and medical information will be accessible to authorized health care providers through DHIN.
Initial

_____ I hereby authorize DHIN to cancel my Request for Non-Participation.
Initial

First Name: _____ Middle Name: _____ Last Name: _____

Previous Last Name: _____ Date of Birth: _____ (Ex: 01/01/1990) Gender: ☐ Female ☐ Male

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone 1: _____ Phone 2: _____

Email Address: _____ Last Four (4) Digits of Social Security Number: _____ (Ex. xxx-xx-1234)

Patient Signature: **X** _____ Date Signed: _____
(If under age 18 years, signature of parent or legal guardian)

For your protection, you must verify your identity in order for DHIN to process this *Cancellation Request*.

Your identity may be verified one of two ways: have this form signed by a Notary Public or by a Health Care Provider (physician, nurse practitioner, or physicians' assistant) licensed in the State of Delaware.

This form must be returned to DHIN in person or by mail with original signatures in black or blue ink.

Section to be completed by a Notary Public or Health Care Provider (MD, DO, OD, DDS, DPM, DC, NP, PA, APN)**:**

I witnessed the above named individual sign this document and the individual is personally known to me or provided me with valid picture identification on this day _____ of _____, 20____.
Day **Month** **Year**

Notary or Provider **Print Name**: _____ Phone Number: _____

Notary or Provider **Signature**: **X** _____ Date Signed: _____

Must be an original signature in black or blue ink.

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Better Communication for Better Healthcare