KanHIT
1000 SW Jackson
Suite 130
Topeka, KS 66612
785-296-8627

REQUEST TO REVOKE RESTRICTIONS ON ELECTRONIC ACCESS TO HEALTH INFORMATION

If you wish to revoke previous restrictions on electronic access to your personal health information, please complete the form, below, and mail to Kansas Health Information Technology ("KanHIT"), at the address listed above.

All information you provide will remain strictly confidential and will be used solely to carry out your request. KanHIT staff will contact you directly if additional information or clarification is required to fulfill your request.

You will receive email confirmation from KanHIT once your request has been implemented. If you do not receive confirmation, contact 785-296-0461 as soon as possible.

For your protection, all requests are subject to verification procedures. If you fail to provide all information necessary to verify your request, it may result in its delay or even denial. Electronic access to health information will be restored as soon as practical.

Please check the appropriate box, below. KanHIT cannot process your request if no box is checked. KanHIT can fulfill your request only if one of the following statements is true.

- ☐ I am the person for whom the request is being made. (***Complete Box 1 only***)
- ☐ I am making the request as the parent or legal guardian of a minor and that minor does not have the legal authority to consent to his/her own medical treatment. (***Complete both boxes***)
- ☐ I have been appointed by a court of proper jurisdiction to act on behalf of the individual for whom I am making the request as his/her legal guardian. (***Complete both boxes***)
- ☐ I have been formally appointed by the individual for whom I am making the request as his/her durable power of attorney and/or durable power of attorney for health care **and** that individual has an impairment that prevents him/her from making decisions on his/her own behalf. (***Complete both boxes***)

By signing below and supplying the information requested in the appropriate boxes below, I now revoke the previous restriction on the electronic access to personal health information and authorized Participants in health information organizations to electronically access such information for purposes of treatment, payment, and health care operations. I understand I can once again restrict access at any time by requesting such restriction be put into place.

By submitting this request, I certify under penalty of perjury that (1) all information I have provided on this form is true and accurate to the best of my knowledge; and (2) I have the authority to make this request.

_____
Signature

_____
Date

BOX 1: Complete the following for the person whose health information will be restricted

Title (Mr./Mrs./Miss/Ms./Dr.):_____ *First Name: _____

Middle Name: _____ *Last Name: _____

Suffix (Jr., Sr., III, etc.): _____ Maiden Name: _____

Other Names, Aliases, or Nicknames: _____

*Birth Date: ____/____/_____ *Gender: _____ Social Security Number: _____

*Address: _____

*City: _____ *State: _____ *Zip: _____

E-mail Address: _____

(*Confirmation of this request will be sent to the e-mail address listed here)*

*Primary Phone#: _____ Alternate Phone#: _____

*Preferred method of contact – check only one:

(In case KanHIT staff requires additional information to implement your request.)

☐ Mail ☐ Email ☐ Primary Phone# ☐ Alt Phone#

List the most frequently visited physicians (name and city):

(In case KanHIT staff requires additional information to implement your request.)

_____

_____

*** Your request cannot be implemented without this information.**

BOX 2: Complete the following regarding yourself only if you are submitting this request on behalf of another individual:

Title (Mr./Mrs./Miss/Ms./Dr.):_____ *First Name: _____

Middle Name: _____ *Last Name: _____

Suffix (Jr., Sr., III, etc.): _____

*Address: _____

*City: _____ *State: _____ *Zip: _____

E-mail Address: _____

(*Confirmation of this request will be sent to the e-mail address listed here)*

*Primary Phone#: _____ Alternate Phone#: _____

*Preferred method of contact – check only one:

(In case KanHIT staff requires additional information to implement your request.)

☐ Mail ☐ Email ☐ Primary Phone# ☐ Alt Phone#

☐ Check here if you are a 42 C.F.R. Part 2 Program submitting Request for Restriction on behalf of a patient.

*** Your request cannot be implemented without this information.**