Provider Location:

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HASA REVOKE OPT-OUT FORM

HEALTHCARE ACCESS SAN ANTONIO

☐ I previously submitted a request to "opt out" of HASA Health Information Exchange System and am now requesting to be reinstated so that my health care information can be electronically accessible to authorized health care providers through the HASA system.

- A separate form must be filled out for each family member who previously opted out and is now requesting to revoke that opt out.
- ALL FIELDS ARE REQUIRED for form to be processed.
- Contact phone number is required in case HASA needs to contact you to ensure accuracy of your demographic information.

Patient Last Name ***First Name*** ***Middle Initial*** ***(Previous Names/Nicknames)***

Mailing Address ***City,*** ***State*** ***Zip Code***

( ) -

Contact Phone Number ***Social Security # (Last 4 digits)*** ***Date of Birth (mm/dd/yyyy)***

Signature of Patient Date Signed

Signature of Parent/Guardian Date Signed

If patient under 18 years, signature of patient guardian

Parent/Guardian Name Parent/Guardian Contact Telephone

☐ Parent ☐ Guardian ☐ Other________________________________

Section to be completed by a Notary Public or Health Care Provider (or office staff):

I witnessed the above named individual signing this document and the individual is personally known to me or provided me with valid picture identification on this day ____of________, 20___

Notary or Provider Signature: ______________________________ Phone Number: ______________________________

Print Name: ______________________________ Date Signed: ______________________________

(Must be original signature in black or blue ink)

PRACTICE ADMINISTRATOR: Please send the completed form via HASAReferral to "HASA consent forms-sent here" (searchable in Location tab) or fax to 210-918-1376