Coordinated Care Health Network

Coordinated Care Health Network (CCHN) is a service that assists health care providers to share patient health information for authorized purposes, including permitted treatment, payment, and health care operations activities through secure, electronic means. Having access to current and complete information from other caregivers can help your health care provider make a better informed decision about your care. Information shared through CCHN is not a comprehensive medical record of your health history, and CCHN is not the only source where health care providers may access or share your health information.

The purpose of this form is to permit you to request that CCHN restrict sharing of your health information for treatment purposes between your health care providers through CCHN. This form does not guarantee CCHN or your health care providers will not access or share your health information for other purposes as set forth in your health care provider's Notice of Privacy Practices.

Please initial that you have read and understand the following statements:

_____ I understand this Participation Change Request is only a request.

_____ I understand this Participation Change Request applies only to sharing of my health information through CCHN.

Select one action:

_____ I request CCHN restrict sharing of my health information for treatment purposes.

_____ I terminate my previous request and authorize CCHN to allow sharing of my health information through CCHN.

Patient Legal First Name	Middle Name	Last name
Other names used (maiden name, nicknames, etc)		
Street Address		
City	State	Zip Code
Phone Number	Date of Birth (MM/DD/YYYY)	Last 4 digits of patient's Social Security Number

Parent / Guardian / Personal Representative Name	Relationship to Patient

_____ _____

Signature of Patient or Patient Representative Date

----------Section below to be completed by a Notary Public or Physician----------

State of _____ County of _____

The foregoing instrument was acknowledged before me this _____ by _____ .
(date) (name of person acknowledged)

Print Name: _____

Signature: _____
Physician or Notary

Notary Stamp if verified by Notary

Please fax this form to: (972) 692 5377