Request to Rescind the Restriction of Disclosure of Health Information

By signing this form, you are revoking your Request to Restrict Disclosure of Health Information, previously signed, and granting permission for your health information or your minor child's health information be made available through IHDE.

Please mail or fax this form to the address or fax number below. Keep a copy of this form for your records.

☐ I wish to revoke my request to restrict disclosure of my health information and make it available to participants in the Idaho Health Data Exchange.

(Please Print Legal Name)

Patient First Name	Middle Initial	Last Name	
Other names you have used (maiden name, etc)			
Street Address			
City		State	Zip Code
Phone Number		Email	
Date of Birth (MM/DD/YYYY)		Gender ☐ M ☐ F	Last 4 digits of patient's social security number
Parent/Guardian/Personal Representative Name (Please print)			Relationship to Patient
Patient or Parent/Guardian Signature			Date

Mail to: Idaho Health Data Exchange
P.O. BOX 190983
Boise, ID 83719

Fax to: 208-803-0031