



### 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 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 the *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 with original signatures in black or blue ink.***

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

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.**