QUALITY HEALTH® N·E·T·W·O·R·K
Improving care through shared technology

QHN Patient Summary Record
Patient Opt-In Form

I previously submitted a request to "opt-out" of the Quality Health Network (QHN) electronic Patient Summary Record (PSR). I am now requesting that access to my health information in the PSR be reinstated so this information can be electronically accessible to authorized healthcare providers through the QHN HIE system.

- A separate form must be filled out for each family member requesting to opt back in to the PSR.
- All fields are required for the form to be processed.
- Contact phone number is required in the event QHN needs to contact you to ensure accuracy of your identifying information.

Patient first name (include complete name)	
Patient middle name	
Patient last name	
All previous names and/or nicknames	
Date of birth (mm/dd/yyyy)	
Mailing address	
City, State, Zip Code	
Contact phone number	

Signature of Patient _____ Date: _____
(or Authorized Representative) If under 18 years, signature of parent or guardian.

Signature of QHN Medical Provider _____ Date: _____

For your protection, QHN requires that you verify your identity in order to process this Request. This form must be completed by a Notary Public. Once notarized the original form must be returned to your QHN Medical Provider.

– – – – – – – – – – Section below to be completed by Notary Public – – – – – – – – – – –

State of: _____ County of: _____

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

Notary Print Name: _____

Notary Signature: _____

Notary Stamp