Participation Change Request

Michigan Health Information Network Shared Services (MiHIN) is a non-profit organization that helps healthcare providers enhance care and reduce costs. This form instructs MiHIN to change an individual'sparticipation status.

Under Michigan law, healthcare organizations can collect, store, and share patient information electronically for treatment, payment, and operational reasons. Michigan law permits citizens to opt out of having their health records shared through Michigan Health Information Network Shared Services. MiHIN is required to show and share health record when state and federal laws require it.

Step 1: Select a participation status.

☐	Request to OPT OUT - I do not want my health records in the MiHIN Longitudinal Health Record (LHR) aka Virtual Integrated Patient Record (VIPR) (unless the law requires it).
☐	Request to OPT IN - I previously opted out, but now wish my health records to beincluded in the MiHIN community health record LHR/ VIPR (unless the law prevents it).

Step 2: Demographic Information

All fields are required, unless noted as "optional". All references below refer to the patient.A legal representative may complete this form for a patient who is incapacitated or is a minor (under 18).

Full Name (First Middle Last)	Date of Birth	
Previous Last Name (optional)	Gender Male ☐ Female ☐	
Street Address		
City	State	Zip Code
Phone	Alternate Phone (optional)	
Signature (Patient or Legal Representative)	Date	
Legal Representative Name (Print)	Relationship to Patient	
If signed by Legal Representative of the patient, select a reason. ☐ Patient is incapacitated ☐ Patient is a minor (under 18 years old)		

Step 3: Identity verification

MiHIN requires identity verification to protect patients. A Notary Public OR a healthcareprovider must verify the patient's identity. Please indicate who is verifying the patients identity.

☐	Notary Public - The completed and notarized form must be MAILED to MiHINwith original signatures in black or blue ink. Michigan Health Information Network Shared Services Attn: Participation Change Request 1140 Abbot Road Unit 1588 East Lansing, MI 48826
☐	Healthcare provider - The completed form must be returned to MiHIN via secureemail: help@mihin.org

The Notary Public OR the Healthcare provider must complete the section below.

I witnessed the above-named individual sign the document and the individual is personallyknown to me or provided me with valid picture identification on this day,

_____*(month)*_____*(day number),*_____*(year).*

Name (print)	Phone Number
Signature	Date