REVOCATION OF OPT-OUT REQUEST

Please complete, sign and return this form only if you had opted out before and have now changed your mind and do not object to your primary care provider (PCP), hospital and/or specialist who manages your care seeing certain electronic health information (not from behavioral health providers or HIV-related information) that the HUSKY Health Program has about you from other providers. Remember that your PCP, hospital or specialist who manages your care may use this information about you for treatment and care management purposes ONLY.

STEP 1: List the member(s) in the household who are 18 years old or older who are now fine with the PCP, hospital and/or specialist seeing electronic health information from other health care providers:

1	Last Name	First Name	Date of Birth (MM/DD/YYYY)	HUSKY ID #
2	Last Name	First Name	Date of Birth (MM/DD/YYYY)	HUSKY ID #
Street Address		Apt. #	City, State, Zip	
Phone Number		Email Address		

STEP 2: List the member(s) in the household who are under 18 years old for whom it is now fine for the PCP, hospital and/or specialist to see electronic health information from other health care providers:

Last Name	First Name	Date of Birth (MM/DD/YYYY)	HUSKY #
Last Name	First Name	Date of Birth (MM/DD/YYYY)	HUSKY #
Last Name	First Name	Date of Birth (MM/DD/YYYY)	HUSKY #
Last Name	First Name	Date of Birth (MM/DD/YYYY)	HUSKY #

STEP 3: Sign as Head of Household or other adult member (Each adult must sign):

By signing this form, you are saying that you have changed your mind and you do not object to the HUSKY Health Program electronically sharing health information about you and/or your children, as listed above, from other providers to your/their PCPs, hospitals and/or specialists for treatment and care management purposes:

1	Signature of Member or Member's Legal Representative	Printed Name of Person who Signed	If Legal Representative, Relationship to Member	Date
2	Signature of Member or Member's Legal Representative	Printed Name of Person who Signed	If Legal Representative, Relationship to Member	Date

PLEASE MAIL COMPLETED FORMS TO:

HUSKY Health
Attention: Compliance
P.O. Box 5005
Wallingford, CT 06492

HUSKY Health Program Member Engagement Services 1.800.859.9889