Charleston Area Medical Center

CommonWell Health Alliance® services ("CommonWell") Patient Opt-In Form

Please print, complete and mail to:

Charleston Area Medical Center
Attn: Health Information Management Department, HIE
130-138 57th Street
Charleston, WV 25304

____**Rescind Opt-Out: I request to terminate my previous decision to opt-out; therefore, I am choosing to opt back in.**

By completing and signing this form, I am allowing my health information to be accessible to my health care providers through CommonWell**.**

Last Name: _____ **First Name:** _____

Email: _____ **Primary Phone #:** _____

Date of Birth: _____ Last 4 Digits of Social Security #: _____

Street Address: _____

City: _____ State: _____ Zip: _____

If this form is submitted by someone other than the person named above, the person submitting the form hereby certifies that he/she is acting as (check one)

☐ Parent
☐ Legal Guardian
☐ Other: _____(Relationship)

_____
Signature