Coordinated Care Oklahoma
Clinical. Trusted. Secure.

Individual Participation Change Request

Coordinated Care Oklahoma (CCO), a Health Information Organization (HIO), assists health care providers who participate in CCO share health information for treatment purposes through secure, electronic means. Having access to up to date and complete information from other caregivers can help a health care provider who is taking care of you.

Information shared through the HIO is not a complete medical record of your health history. The HIO is not the only source where health care providers may access or share your health information.

The purpose of this Participation Change Request is to permit you to request that CCO restrict sharing of your health information for treatment purposes between your health care providers through the HIO. CCO is not required to agree to any request for restriction. Where possible, CCO may take reasonable steps to accommodate a request. This form does not guarantee CCO or your health care providers will not access or share your health information for other purposes as set forth in your health care provider's Notice of Privacy Practices.

Please initial that you have read and understand the following statements:

_____ I understand this Participation Change Request applies only to sharing of my health information through CCO for treatment purposes. I understand when I seek treatment from a health care provider, my treating provider may request and receive my health information from other providers or sources using other methods permitted by law, such as fax or mail.

_____ I understand this Participation Change Request is only a request. CCO and/or my health care providers are not legally required to agree to any request for restriction. In the event CCO agrees to this request, CCO and/or my health care providers may continue to access or share my health information as set forth in my health care provider's Notice of Privacy Practices.

***Select one action:**

_____ I request CCO restrict sharing of my health information for treatment purposes through the HIO.

_____ I terminate my previous request and authorize CCO to allow sharing of my health information for treatment purposes through the HIO.

Patient Legal First Name	Middle Name	Last name
Other names used (maiden name, nicknames, etc)		
Street Address		
City	State	Zip Code
Phone Number	Date of Birth (MM/DD/YYYY)	Last 4 digits of patient's Social Security Number

Parent / Guardian / Personal Representative Name	Relationship to Patient

_____ _____
Signature of Patient or Patient Representative Date

----------Section below to be completed by a Notary Public or Physician----------

State of _____ County of _____

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

Print Name: _____

Signature: _____
Physician or Notary

Notary Stamp if verified by Notary

Please mail this form to: Coordinated Care Oklahoma - 111 N. Peters Ave. Suite 600 - Norman, Oklahoma - 73069