Vandalia Health

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

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

Please complete and submit online or print and mail to:

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

Charleston Area Medical Center, Greenbrier Valley Medical Center, and Plateau Medical Center may share my health information with CommonWell.

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 (if you are printing and mailing this in)