GRAChIE Health Information Exchange
Opt-Back-In Request Form

February 2026

I previously submitted a request to "opt-out" of the GRAChIE health information exchange (HIE) and am now requesting to be reinstated so that my health information can be electronically accessible to authorized health care providers through the HIE.

This will include health information that was gathered before I sign this form. I understand:

- Each family member must submit a separate form.
- All fields are required for the form to be processed.
- For my protection, GRAChIE requires that I return this form to my health care provider so that they may verify my identity.

For providers: To manage patient consent, download and complete the form (notarization not required), then submit as directed.

Practice Name & Provider Name:
Patient First and Middle Name:
Last Name:
Previous Names/Nicknames:
Date of Birth (mm/dd/yyyy):
Last 4 Digits of Social
Street Address:
City, State, ZIP Code:
Contact Phone Number:

Signature of Patient or Legal Representative **Date**

□ Check if signer is a Legal Representative

Identity Verification

Notary Public

State of _____ County of _____ Notary Stamp

The foregoing instrument was acknowledged before me on:

_____ _____

(Date) (Name of person acknowledged)

Notary Signature: _____ Name: _____

Deliver to GRAChIE-participating provider **OR** notarize and mail to:	GRAChIE | Attn: Opt-Out P.O. Box 470 Sandersville, GA 31082

Please note that requests will be processed within 10 business days of receipt.