Velatura Opt-Out Request Form

Updated
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Velatura is a secure health information exchange network that enables authorized healthcare providers to share your health information for treatment and essential healthcare operations. By initialing below, I confirm that I have read and understand the following:

_____ I am choosing to opt out of having my health information shared through the Velatura network.

_____ I understand that my information may still be sent by fax, mail, or other legal methods if needed for treatment or required by law.

_____ I may opt back in at any time by submitting an Opt-In Request Form, available from any participating provider or by visiting www.velatura.org/patientconsent.

_____ A separate form must be completed for each individual requesting to opt out.

Take this completed form to your healthcare provider who participates in Velatura. Your provider will verify your identity and submit the form on your behalf.

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
□ Check if signer is a Legal Representative

Date