**How to opt-out of Manifest MedEx**   
You have three options to opt-out of Manifest MedEx:

1. Call Manifest MedEx support at 1 (800) 490-7617
2. Go online and complete MX’s online form at: <https://www.manifestmedex.org/opt-out>
3. Complete and scan this form and email to [support@manifestmedex.org](mailto:support@manifestmedex.org) or [opt-out@manifestmedex.org](mailto:opt-out@manifestmedex.org)

**What it means to opt-out of Manifest MedEx**  
Manifest MedEx (MX) facilitates electronic sharing of your health records between members of your healthcare team to help make your medical treatment safer and more effective. Participation in Manifest MedEx is voluntary and free of charge.

Opt-out provisions are not applicable to Patient Data which providers or health plans share to support authorization of services to patients, where those patients have already been informed of such sharing by a provider or health plan Notice of Privacy Practices.

By opting-out of Manifest MedEx, you are choosing ***not*** to have your health records accessible by your healthcare team (including your primary care provider, care manager at your health plan, etc.) through the Manifest MedEx system. If you choose to opt-out of MX with one provider this means your information will not be shared with **any** provider, even in the case of an emergency.

**What to expect after you opt-out of Manifest MedEx**  
If you provide an email address, then you will receive an email confirmation that your opt-out request has been processed.

**What if my request to opt-out was made in error, or I changed my mind and want to participate?**  
You can change your mind and opt back in by calling (800) 490-7617 or by filling out a form available at: <https://www.manifestmedex.org/opt-out> or <https://www.manifestmedex.org/opt-out-2/>

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**Patient information [PATIENT MUST SIGN if the Provider is sending the form in on behalf of the patient]**

First Name Middle Name Last Name

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Previous First Name Previous Last Name (Maiden, Other)

Gender : Female Male Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Street Address Apartment, Suite

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City State Zip Code

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address Phone Alternate PhoneBottom of Form

**Person Completing Form (Complete this section only if you are not the patient named above)**

**IMPORTANT:** You may only elect to opt-out of Manifest MedEx for yourself and other individuals you are authorized by law to act on behalf of, such as a minor child, other legal dependent, or someone who has given you their healthcare power of attorney. Manifest MedEx reserves the right to require you to submit proof of your authority when acting on behalf of another person. Individuals submitting false information may be subject to prosecution or liability for civil claims for fraud or misrepresentation.

**I am completing this form for someone else. My relationship to the patient is:**

Parent Spouse   
Caregiver Medical Provider/representative

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First Name Last Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**[LIST medical provider/healthcare entity with email and phone number]**

**\*\*PATIENT SIGNATURE BELOW IS REQUIRED WHEN A PROVIDER SUBMITS THIS FORM ON BEHALF OF A PATIENT**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT SIGNATURE/NAME**

**By signing here, I authorize my medical provider to submit this form on my behalf**