

Objection (or Withdrawal of Objection) Form

Participating in CommonWell Health Alliance

Patient information (this information is necessary to properly identify the patient)

Patient Name _____ Date of Birth _____
First Name Middle Initial Last Name (month / day / year)
Preferred Name _____ Gender _____
Pronouns _____
Address _____ City _____ State _____ Zip _____
Phone _____ Email _____

Parent/guardian information (required if form is completed for a child younger than 16 years of age)

Relationship to Patient _____
Patient Name _____ Date of Birth _____
First Name Middle Initial Last Name (month / day / year)
Preferred Name _____ Gender _____
Pronouns _____
Address _____ City _____ State _____ Zip _____
Phone _____ Email _____

I OBJECT to sharing my health information through the CommonWell Health Alliance. I understand that this prevents my doctor or other healthcare providers from being able to electronically access my records for health information that comes from health providers outside of MIT Health.

I WITHDRAW MY PREVIOUS OBJECTION to the sharing of health information through the CommonWell Health Alliance. I understand that by signing and submitting this form, other healthcare providers may view my health information as allowed by law.

Signature of Patient, or Parent/Guardian (if child is younger than 18 years of age):

Signature _____ Date _____

Please print or scan and return to

Medical Records

E23-023

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