Ambient Healthcare

I acknowledge that I received and read the Notice of Health Information Practices. I understand that my healthcare provider participates in Contexture, Arizona's health information exchange (HIE). I understand that my health information may be securely shared through the HIE, unless I complete and return an Opt Out Form to my healthcare provider.

Patient Name: _____

Patient Date of Birth: _____

Patient Signature: _____

Date Signed: _____

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