



Cancellation of a Non-Participation Request Michigan Health Connect

Please initial that you have read and understand each of the following statements:

_____ I have previously chosen not to participate in MHC and completed a Request for Non-Participation form.

_____ I understand that by submitting this *Cancellation Request* that my test results and medical information will be accessible to authorized health care providers through MHC.

_____ I hereby authorize MHC to cancel my request for non-participation.

First Name: _____ Middle Name: _____ Last Name: _____

Previous Last Name: _____ Date of Birth: _____ (Ex: mm/dd/yyyy) Gender: Male Female

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (_____) _____ Alternate Phone: (_____) _____

E-mail Address: _____ Last Four (4) Digits of Social Security Number: _____ (Ex. xxx-xx-1234)

Patient Signature: X _____ Date Signed: _____
(If under the age of 18, signature of parent or legal guardian)

For your protection, you must verify your identity in order for MHC to process the Cancellation Request.

Your identity may be verified one of two ways: You must either have this form signed by a Notary Public or by a Health Care Provider (physician, nurse practitioner, or physicians' assistant) licensed in the State of Michigan.

This form must be returned to MHC with original signatures in black or blue ink.

Section to be completed by a Notary Public or Health Care Provider (MD, DO, NP, PA):

I witnessed the above named individual sign this document and the individual is personally known to me or provided me with valid picture identification on this day _____ of _____, 20____.
Day Month Year

Notary or Provider
Print Name: _____ Phone Number: _____

Provider License Number: _____

Notary or Provider
Signature: X _____ Date Signed: _____

Must be an original signature in black or blue ink.