collectivemedical®

Request to Opt-In Form

Your hospital or healthcare provider participates in the Collective Network to share electronic health information for the purpose of coordinating the provision of safe, convenient, integrated care to you through Collective Medical's services, specifically the Collective Platform.

Instructions

If you previously opted out of participation in the Collective Platform and now desire to so participate, you may do so by (1) acknowledging your understanding of **each** of the statements listed below by checking the corresponding boxes, (2) providing **all** the identifying information requested below, (3) signing and dating this form in the presence of your healthcare provider, (4) obtaining said healthcare provider's signed certification of your signature, and (5) delivering this completed form to CMT by fax at 855.343.7671 or by mail at **Collective Medical; ATTN: Opt Out; 2855 Cottonwood Parkway, #200; Cottonwood Heights, UT 84121**.

I understand that:

[check each box]

- ☐ Once Collective has processed my Request to Opt-In form, my health information will be shared through the Collective Platform;
- ☐ My hospital or healthcare provider may continue to share my health information with other treating providers by mail, phone, fax, secure email, electronic medical record, or other electronic information systems;
- ☐ My request to opt in will be effective three (3) to five (5) business days after Collective receives my request;
- ☐ I may choose to stop participating in the Collective Platform again at any time by submitting to Collective a *Request to Opt-Out Form*;

My Information and Signature:

Patient First Name	Patient Middle Name	Patient Last Name		Social Security Number
Patient Nickname / Previous Name(s)	Patient Gender (M/F)	Patient Date of Birth (mm/dd/yyyy)		Patient Primary Phone Number
Patient Address		City	State	ZIP
Signature of Patient (if signing for self)			Date Signed (mm/dd/yyyy)	
Signature of Legal Authorized Representative on behalf of patient (if applicable)			Relationship / Legal Authority to Individual	

[TO BE COMPLETED BY HOSPITAL OR MEDICAL OFFICE STAFF]

Provider Certification

I witnessed the above named individual sign this Request to Opt-In Form and the individual is personally known to me or provided me with valid picture identification on this _____ day of _____, 20_____.

Signature of Health Care Provider Making Certification	Name & Title of Provider or Staff Member