

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 wish to opt out of participation in the Collective Platform, 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]

- There are risks associated with opting out of the Collective Platform, including the possibility that my treating providers may not have up to-date information about my health needs, which may negatively impact the care I receive and increase the risk of unnecessary costs for duplicate tests or procedures;
- Once Collective has processed my Request to Opt-Out form, my health information will not be shared through the Collective Platform **except as noted in the Collective Patient Notice;**
- Opting out will not prevent my hospital or healthcare provider from sharing my health information with other treating providers by phone, fax, mail if requested;
- Even after opting out, my hospital or healthcare provider may still share my health record information through secure email, electronic medical record, or other electronic information systems;
- My Request to Opt-Out will be effective three (3) to five (5) business days after Collective receives my request;
- Information which has been shared about me through the Collective Platform before my effectiveness of my decision to opt-out will remain with the organizations which received it;
- I may choose to participate in the Collective Platform again at any time by submitting to Collective a *Request to Opt-In 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-Out 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	
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