CollectiveMedical TECHNOLOGIES

Request to Opt-In Form

Your hospital or health care provider participates in the Collective Medical Technologies (CMT) network to share electronic health information (CMT Network) in order to coordinate the provision of safe, convenient, integrated care to you through CMT's services, including EDIE and PreManage (CMT Network Services).

Instructions

If you previously opted out of participating in the CMT Network Services 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*** of the identifying information requested below, (3) signing and dating this form in the presence of your healthcare provider, (4) obtaining such 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 Technologies, Inc., ATTN: Opt In, 4760 S. Highland Dr., STE 217, Holladay, UT 84117.**

I understand that:

[check each box]

☐ Once CMT has processed my Request to Opt-In Form, my health information will be shared through CMT Network Services.

☐ My hospital or health care 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 CMT receives my request.

☐ I understand that I may choose to stop participating in the CMT Network Services again at any time by submitting to CMT a "Request to Opt-Out Form."

My Information and Signature:

Patient First Name	Patient Middle Name	Patient Last Name	Social Security #
Patient Nickname/Previous Name(s)	Patient Gender (M/F)	Patient Date of Birth (mm/dd/yyyy)	Patient Primary Phone #
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