Request to Opt-Out 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 wish to opt out of participation in the CMT Network Services, 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 Out, 4760 S. Highland Dr., STE 217, Holladay, UT 84117.**

I understand that:

[check each box]

- ☐ There are risks associated with opting out of the CMT Network Services, 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 CMT has processed my Request to Opt-Out Form, my health information will not be shared through the CMT Network Services, ***except as noted in the CMT Patient Notice***.
- ☐ Opting out will not prevent my hospital or health care provider from sharing my health information with other treating providers by phone, fax, mail if requested.
- ☐ Even after opting out, my hospital or health care 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 CMT receives my request.
- ☐ Information which has been shared about me through the CMT Network Services before the effectiveness of my decision to opt-out will remain with the organizations which received it.
- ☐ I understand that I may choose to participate in the CMT Network Services again at any time by submitting to CMT a "Request to Opt-In 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-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