Carequality Network & CommonWell Health Alliance Opt Out Form

Information for Patient Opting Out

First Name*_____________________________________Middle Name _____________________________

Last Name*____

Address Line 1*____

Address Line 2 ____

City*__________________________________ State*_______ Zip Code*___________________________

Primary Phone Number* ____

Secondary Phone Number ____

Email ____

Date of Birth* ____________________________________Sex (M/F)* ______________________________

** Required*

If this form is signed by someone other than the person named above, the person signing the form hereby certifies that he/she is acting as: (CHECK ONE) ____ Parent ____ Legal Guardian ____ Other (Specify Relationship) ________________________ for the person named above.

Contact information for individual completing this form if other than patient:

Printed Name ________________________________ Phone Number ______________________________

*Patient Information (please print clearly)**

Printed Name ________________________________ Signature ___________________________________

Date ____

Please email this completed form to information@primaryhealth.com or mail to:

Primary Health Medical Group
c/o Privacy Officer
10482 W. Carlton Bay Drive
Garden City, ID 83714