



Carequality Network, CommonWell Health Alliance and TEFCA 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