Patient Opt-Out Form

Fill out this form and mail to:

Patient Opt-Out
Oregon Health Care Quality Corporation
520 SW 6th Ave, Suite 830
Portland, OR 97204

I Choose NOT to Take Part

First, Middle, and Last Name _____

Street _____

City, State, Zip _____

Date of Birth_____Gender (male/female) _____

When I sign and mail in this form, I understand that I am choosing for my personal health information from insurance bills **not** to be included in Q Corp's *Compare Your Care* initiative. I also understand that health information about me will not be available through this system to assist my doctors and health care team with my health care. I also understand that my information will not be used to measure and report the quality of health care in Oregon.

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Signature of Patient or Guardian Date