



HIPAA/Protected Health Information (PHI) Disclosure

Patient Name -PRINT

Boston Mountain Rural Health Center, Inc. (BMRHC) is committed to providing security for patient privacy and confidentiality. This organization collects, uses, and discloses personal health information only in conformance with state and federal laws and your personal authorization. Please understand that this may include the collection of other sources of information available, such as medication and prescription history and verification of insurance eligibility.

BMRHC participates in programs, such as the State Health Alliance for Records Exchange (SHARE), CommonWell and CareQuality to share and receive your health information among your doctors, hospitals, labs, radiology centers, and other health care providers through secure, electronic means. With access to your up-to-date health information, your doctor can provide safer, more effective health care that is tailored to your personal medical needs. **If you wish to opt-out, you must ask your health care provider for and complete an Opt-Out Form.** You can also opt-out for your minor child (under the age of 18) using the same process.

In an effort to serve you more efficiently, BMRHC opts patients into an automated system to remind you of appointments, lab notices by portal, health maintenance reminders, prescription confirmation and general notifications. You will be contacted using the latest contact information on file. Please understand that it is your responsibility to inform BMRHC when there are updates to your personal contact information. You may opt out at any time.

BMRHC offers access to medical information through the patient portal and/or Healow application. Please understand that it is your responsibility to inform BMRHC when there are updates to your personal contact information. I understand that it is my responsibility to let BMRHC know when my email address has changed.

I wish to Web Enable my account (Patient Portal) **ONLY FOR PATIENTS 18 YEARS AND OLDER**

Email: _____

BMRHC also realizes you may have family members or significant people whom you may wish your provider speak with regarding your healthcare information. Please specify the individual(s) and their relationship to you so that your healthcare team has permission to discuss your Protected Health Information (PHI) healthcare information. It is your responsibility to communicate any changes to BMRHC staff and request an update in your medical record.

Individual's Name	Phone Number	Relationship to You
_____	_____	_____
_____	_____	_____
_____	_____	_____

By signing below, I am acknowledging that I am the patient or the authorized representative for the patient.

Patient Signature Or Designated Representative

Date