BOSTON MOUNTAIN
RURAL HEALTH CENTER, INC.

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. I agree that I have received a copy of the BMRHC Notice of Privacy Practice.

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 an Opt-Out Form.** You can also opt-out for your minor child (under the age of 18) using the same process.

COMMUNICATIONS REGARDING MY CARE and MY ACCOUNT: I agree that BMRHC, any other collection or servicing agency, or agencies retained by BMRHC ("collectors") to collect a debt that I owe to BMRHC may contact me by telephone or text message at any number associated with my personal demographic information. I agree that BMRHC and other approved partners retained by BMRHC may contact me by telephone or text message at any number associated with my personal demographic information for the purpose of including but not limited to, lab notifications, prescription confirmations, care coordination, quality improvement activities, appointment reminders, wellness campaign reminders and insurance coverage/network status. I understand that this contact for collection and care services includes but is not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that BMRHC may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voicemail messages. I understand that it is my responsibility to notify BMRHC of any updates to my personal contact information. ***You can OPT OUT at any time by notifying BMRHC staff or replying STOP to any text message.***

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

Revised July 9, 2012; 9/15; 03/10/2020, 12/22, 6/2025