RURAL MEDICAL SERVICES, INC.

To be compliant with HIPAA Privacy Regulations, we must have the following information on file:

Patients Name: _____

Date of Birth: _____ Social Security Number: _____

I, _____, authorize Rural Medical Services, Inc., its providers and employees to do the following:

(PLEASE CIRCLE WHICH YOU PREFER)

They MAY/MAY NOT leave a message at my home/cell number.*

They MAY/MAY NOT call me at work and/or leave a message.*

They MAY/MAY NOT contact me by mail.

They MAY/MAY NOT leave test results on my answering machine/voicemail.*

They MAY/MAY NOT send appointment reminders and other information via text message.*

They MAY give results to and discuss my healthcare, insurance, and billing with:

Name: _____Relationship: _____ Phone: _____

Name: _____Relationship: _____ Phone: _____

*If consent is given for using your phone number as a means of communication through text messaging, answering machines or voicemail please provide us with your most current numbers:

Home Number: _____

Cell Phone Number: _____

Work Number: _____

This authorization will remain in effect until I provide written instructions to do otherwise.

A copy of our privacy notice is also posted in our waiting area. If you have any objection to this form, please ask to speak with our HIPAA Privacy Officer in person, or by phone at our corporate number (423) 613-3300.

_____ _____

Patient Signature Date

_____ _____

Parent or Guardian Signature if patient is minor Date

_____ _____

Witness Date