HIPAA Acknowledgement Form for Email Transmission of Protected Health Information or PHI

By signing below, I acknowledge that it is within my rights to receive protected health information (PHI) by personal email, fax, or the patient portal from any entity within Rocky Mountain Healthcare Companies. If I choose personal email or an unsecured fax location to receive any or all of my requested records, I understand that these methods are less secure than other means of encrypted email, or when receipt is from our official records retrieval system, ShareCare®.

Less secure forms of transmission, including personal email are at a higher risk for being intercepted and viewed by unintended recipients. I hereby acknowledge this risk by signing below, and have added the specific email address to my patient registration form, specifying the types of information that I request receiving in this manner.

_______________________________ _________________

Printed Name Date

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Signature