Patient Portal Consent

Missouri Highlands Health Care provides patients of the health center with a secure Patient Portal web site. This "portal" is intended to improve access to medical records and enhance patient-provider communications. Patients must be 18 years of age to access the portal and must sign-up with the front desk via this form, at the time of their office visit.

The Patient Portal allows for electronic access to view personal medical history, update personal information, schedule appointments & ensure patient information is correct & complete. **The portal is NOT to be used to communicate Urgent or Emergency issues. If you are experiencing an emergency please call 911. 911 can be called in the following counties; Butler, Iron, Reynolds and Ripley. For emergencies in Carter County please dial 573-323-4510, in Shannon County dial 573-226-3915, and in Wayne County dial 573-224-3219.**

Please read the following carefully:

- **ALL communication via the Patient Portal will be included in your permanent patient record**
- The Patient Portal is being provided to you at no cost. We do not sell or give away any private information, including email addresses, without your written consent. We reserve the right to suspend or terminate the Patient Portal at any time and for any reason.
- Staff members other than your primary care provider will be involved in receiving your messages, and directing them to the right person/place. These staff members will be designated and may be a medical assistant, billing clerk, or front desk staff.
- Refill requests for controlled substances **CANNOT** be made through the portal. Please call your primary care provider to set up an appointment.
- It is your responsibility to protect your password from any one not authorized to access your information. If your password is stolen it is your responsibility to contact us and let us know. You agree to not hold Missouri Highlands Health Care responsible for any violations beyond our control.
- Please refer to our Notice of Privacy Practices for information on how private health information is handled in our office.

Please complete the following information and sign on the signature line below.

Name:		Date of Birth:
Address (Number):		
City:	State:	Zip Code:
Email Address:		
Signature:		Date: