BIG SKY CARE CONNECT

Opt Out/Revoke Opt Out Form

Big Sky Care Connect (BSCC) is a secure health information exchange that allows your health care professionals to view your health information such as medicines, allergies, test results, health problems, prior care and treatments to help them make better decisions about your care. All patient information is encrypted and sent over a secure network. Only Participants and Authorized Users may access your information, and only for permitted purposes. Your health information is included in BSCC by default, but your participation is voluntary.

If you decide to opt out, your health records will not be searchable through the BSCC. You will NOT be denied medical care if you decide to opt out. Your demographic information will remain accessible, and a treating provider will still be able to receive your lab results, radiology reports, and other information through traditional fax, mail, or other electronic communications. In an emergency situation where absence of immediate medical attention could reasonably be expected to result in placing your health in serious jeopardy, the treating provider has the ability to access your information through BSCC to assist with your treatment.

You may choose to opt out of participation in the BSCC or change a prior election by completing and signing this form. The form can be turned into your provider or the form can be completed online at https://www.mtbscc.org/.

PATIENT INFORMATION

Legal Name (Full Name, including Middle Name)		Date of Birth	
Mailing Address	City	State	Zip Code
Email Address		Phone Number	

REQUESTING INDIVIDUAL - Please choose one of the following options:

- (•) I am the person for whom the request is being made.
- ( ) I am making the request as the parent or legal guardian of a minor and that minor does not have the legal authority to consent to his/her own medical treatment.
- ( ) I have been appointed by a court of proper jurisdiction to act on behalf of the individual for whom I am making the request as his/her legal guardian.
- ( ) I have been formally appointed by the individual for whom I am making the request as his/her durable power of attorney for healthcare and that individual has an impairment that prevents him/her form making decisions on his/her own behalf.

CONSENT DECISION - Please choose one of the following options:

- ( ) I request to opt out of participating in BSCC.
- (•) I want to revoke my prior opt out choice and fully participate in BSCC.

Name of Legal Representative (If Applicable):

Signature of Patient or Patient's Legal Representative

Date Signed

This project is funded in whole or in part under a Contract with the Montana Department of Public Health and Human Services. The statements herein do not necessarily reflect the opinion of the Department.