MaxHealth
Family, Internal & Sports Medicine

Patient Name: _____ Date of Birth: _____

Patient Confidentiality and Treatment of Private Medical Information

1. Please list people (and their relation to you) to whom we may release information about your medical condition and/or treatment. Please include anyone who may pick up prescriptions, reports, x-rays, etc. for you. ***Please note: for minors, the parents &/or legal guardians must be listed below, even if completed by a parent or legal guardian.***

Name	**Relationship to Patient**

2. How can we communicate confidential information (e.g., lab results, referrals, diagnostic test results, billing inquiries, appointment reminders)? ***Please see Email & standard SMS Messaging Consent below.***

- ❑ **Home/Cell Phone (circle one)?** Yes No

  Is it permissible to leave voice messages or messages with other people who may answer the telephone (circle one)? Yes No

- ❑ **Work Phone (circle one)?** Yes No

  Is it permissible to leave voice messages or messages with other people who may answer the telephone (circle one)? Yes No

Notice of Privacy Practices Acknowledgement

By signing below, you acknowledge that you have received the **Notice of Privacy Practices** and you consent to the use and disclosure of your medical information except as expressly stated below. You understand that ***MaxHealth*** has the right to change its **Notice of Privacy Practices** and that you may contact ***MaxHealth*** at any time if you have any questions.

I hereby request the following restrictions on the use and/or disclosure of my information. I understand that you are not required to agree to my requested restrictions and will notify me, in writing, if my request(s) is denied.

Patient (or guardian) Signature: _____ Date: _____

Print Name: _____ Relationship to Patient if a minor: _____

Patient Consent to Communicate via Email and Standard SMS Messaging

Patient Name: _____ Patient DOB: _____

☐ **Yes, I choose to participate in email &/or standard SMS messaging communication.**

I, _____, hereby consent and state my preference to have **Elis Medical Corporation dba MaxHealth Family, Internal & Sports Medicine** communicate with me by email or standard SMS messaging regarding various aspects of my (or my child's) medical care, which may include, but shall not be limited to, test results, prescriptions, appointments, and billing. I understand that text messages are not a substitute for professional or medical attention.

I understand that email and standard SMS messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS messaging regarding my medical care might be intercepted and read by a third party.

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Please check one or both communication methods and provide the requested information.

❑ Email:

E-Mail Address: _____

❑ Standard SMS Messaging:

1. Cell Phone Number: _____ Belongs to: _____
2. Cell Phone Number: _____ Belongs to: _____
3. Cell Phone Number: _____ Belongs to: _____

☐ **No thanks, I choose not to participate in email and standard SMS text messages communication.**

Patient (or guardian) Signature: _____ Date: _____

Print Name: _____ Relationship to Patient if a minor: _____