Belt Line Medical Clinic
"Personalized Medicine For A Healthier You"

Authorization To Communicate Protected Health Information (PHI) Via EMAIL and/or TEXT

And

Disclaimer Re: Electronic Communications

Please Print

First Name, MI, Last Name:			
Date of Birth: (mm/dd/yyyy):			Gender: ☐ Male ☐ Female ☐ Other
Home Address:			
Telephone:	Cell:	Home:	Other:
E-mail address:			

Your authorization to communicate by email and/or text will permit your **Direct Care Provider** to exchange information with you more efficiently and will offer benefits you as a patient and member.

At the same time, we recognize that email and text messaging are not a completely secure means of communication.

You are not required to authorize the use of email and text messages and your decision to not authorize electronic communication will not affect your health care in any way. And you may *discontinue your authorization* of the use of email and text messages at any time by *completing the form on the following page.*

We have taken specific steps under the Health Insurance Portability Accountability Act (HIPAA) to protect all personal health information and request that members give this authorization so that we can more efficiently communicate with you. At any time, you may request a copy of our Clinic *Notice of Privacy Practices*.

Preferred communication: ☐ Email ☐ Text ☐ Either

Authorization To Communicate Protected Health Information (PHI)

☐ I authorize my health care provider and clinical staff to communicate with me by email and/or text (as indicated above) regarding the course of my medical care, treatment and diagnostic test results.

☐ I authorize Clinic administrative staff to communicate with me by email and/or text (as indicated above) regarding my membership account status.

Member or patient representative's email address and/or cell phone number: (*please print*)

_____ _____

EMAIL ADDRESS CELL PHONE NUMBER

signature required on next page

Notice Of Change To Email Address and/or Cell Phone Number

☐ I am changing the email address and or cell phone number to be used for communications with **the Clinic**. New email address and/or Cell number:

EMAIL ADDRESS _____ CELL PHONE NUMBER _____

Discontinue Authorization To Communicate Protected Health Information (PHI)

☐ I no longer wish to communicate via email and or text.

- ☐ I understand that I have a choice to authorize either email or text message communication or both, and that email and/or text transmissions between me and my Clinic provider will become part of my medical record. These email/text transmissions may be disclosed in accordance with the ***Notice of Privacy Practices***.
- ☐ I understand that, once information is disclosed pursuant to the Authorization, it is possible that it could be disclosed by the entity that receives it for authorized purposes under the ***Notice of Privacy Practices***.
- ☐ I understand that I have the right to revoke this Authorization at any time by indicating so above. If I want to revoke this authorization, I must do so in writing and address it to the entity that I had previously authorized to disclose my information. I understand that if I revoke this Authorization, it will not apply to any information already released as a result of this authorization.
- ☐ I understand that this Authorization is voluntary and that I may refuse to sign it. I also understand that the institutions or individuals named above cannot deny or refuse to provide treatment, payment, membership or eligibility for Clinic services if I refuse to sign this Authorization.

I have read and understand the above, and the ***Disclaimer/Alert for Electronic Communications*** *(next page)* and agree that email and/or text messages may include my protected health information and are not a completely secure means of communication.

I have received and/or reviewed the ***Notice of Privacy Practices***.

Member or Patient Representative Signature _____ Date _____

Member's Printed Name _____ Date of Birth _____

Patient Representative's Printed Name _____ Relation _____

Please note that this Authorization is not valid unless completed in full.
This Authorization will not expire unless revoked in writing.

Rev. 2015-12

Disclaimer/Alert for Electronic Communications of Any Kind

Patients and/or their representatives who want to communicate with their health care providers by email and or text should consider all of the following issues before signing the Authorization to Communicate Protected Health Information Via Email/Text:

1. Email/text transmissions can be forwarded, intercepted, printed and stored by others.
2. Email/text communication is a convenience and is not appropriate for emergencies or time-sensitive issues.
3. Highly sensitive or personal information should only be communicated by email/text at the patient's discretion (such as HIV status, other sexually transmitted disease, mental illness, substance abuse, or workers compensation claims).
4. Employers generally have the right to access any email/text received or sent by a person at work.
5. Staff other than the health care provider may read and process email/text.
6. Clinically relevant messages and responses will be documented in the medical record at the provider's discretion.
7. Communication guidelines must be defined between the clinician and the patient, including
   - How often email/text will be checked,
   - Instructions for when and how to escalate to phone calls and office visits, and
   - Types of communication that are appropriate for email/text.
8. Email messages content must include
   - The subject of the message in the subject line (i.e., prescription refill, appointment request, etc.) and
   - Clear patient identification including patient name, telephone number in the body of message.
9. Health care provider is not liable for information lost or misdirected due to technical errors or failures.