

AUTHORIZATION FOR USE AND DISCLOSURE ACKNOWLEDGEMENT OF TEXTING RISK

For services provided by Adapt Integrated Health Care, hereafter referred to as the “Health Center”

By completing this form, I authorize all Health Center office staff, healthcare providers, and any agents or independent contractors acting at and under the direction of same to leave messages regarding appointments, test results, or diagnostic results on my answering machine/voicemail at the designated number(s), and/or with the designated family member/friend(s), and/or to disclose my health information to the designated family member/friend(s) as described below.

Health Center’s policy is to discourage staff from communicating with clients via text. Communicating through text messages can lead to unintended consequences. Private information, your role as a client/patient at Health Center, or Protected Health Information (PHI) may be seen by people who you do not want to see it.

If you choose to have staff communicate with you by text because you have no other way to communicate or you prefer it, here is a list of possible ways your information could be inadvertently disclosed. There may be other ways in which this texting can result in your information being disclosed that are not on this list. Some things to consider:

- Messages are often displayed on the phone automatically and you may not be nearby to monitor the device—a person could inadvertently or intentionally read a message
- A person could use the phone pretending to be you and the person on the other end would not know
- If a person gets access to your phone when you are not present, they could read through sent and received texts, even months or years later

If I request that a Health Center staff member communicate with me via text and I choose not to use a secure app, I understand that I may be putting my confidentiality and privacy at risk. By signing this form, I am acknowledging that I have been advised of the risk and I will hold Health Center harmless for any disclosures that occur because of this method of communication.

I am also consenting to receive text reminders for upcoming appointments. I understand that I can opt out at any time by text STOP to the appointment reminder text message.

Please initial or mark as not applicable (N/A) all authorization(s):

_____ Authorization to leave messages concerning appointment information, test results or diagnostic results on the following answering machine/voicemail(s) or email.

_____ (*Cell phone) _____ (Message phone) _____ (Email)

Please choose: _____ VOICE _____ TEXT

If you are not available at the time that we call, please list below those individuals with whom we can leave a message or briefly discuss your medical information.			Authorization to leave messages concerning appointment information with designated family member/friend(s).	Authorization to disclose my health information to designated family member/friend(s).
Name	Relationship	Phone Number	<i>Initial Below</i>	<i>Initial Below</i>

I have read and agree to the statements above.

 Patient or Guardian / Personal Representative signature
 (circle one)

 Date

 Printed name of Patient

 Printed name of Signatory and relationship, if not Patient