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HIPAA – PATIENT CONSENT FOR USE OF ELECTRONIC COMMUNICATION

Patient's Name: _____ Date of Birth: _____

Account Number: _____

My signature below is authorizing and giving my consent for detailed messages to be left on an email, a cellular device, a home machine or any other technological device.

Email Address:
Cellular Number:
Home Number:

- With my consent, **South Lake OB/GYN & Advanced Surgery** may mail, email, text, call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, patient statements, insurance items and any communication pertaining to my clinical care; including laboratory results, diagnostic results, among others.
- With my consent, **South Lake OB/GYN & Advanced Surgery** may disclose my PHI to any hospital, physician or surgery center to assist my TPO. These items may include laboratory results, diagnostic results, insurance items and any other health information pertaining to my treatment and care.
- I have the right to request that **South Lake OB/GYN & Advanced Surgery** restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions; but if it does, it is bound by this agreement.

I agree and offer no objection to the verbal release of protected health information to the person(s) listed below. I also authorize these persons to pick up prescriptions, notes or other medical information on my behalf.

Person:	Relationship to patient:
Person:	Relationship to patient:
Person:	Relationship to patient:

Patient Signature: _____ Date Signed: _____

Witness Signature: _____ Date Signed: _____