Central Florida
HEARING SERVICES

Informative. Compassionate. Personalized.

Patient Authorization Disclosure/Electronic Mail or Fax

In general, the HIPAA Privacy Rules give individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual's home. The patient may revoke or change this authorization at any time with a written request. Please designate whom the staff may discuss your healthcare and scheduling needs, as well as billing issues, with. ☐ Only disclose information to myself.

I ____ wish to be contacted by:

☐ **HOME** ☐ **CELL PHONE** ☐ **WORK PHONE**
☐ OK to leave message with detailed information ☐ Leave message with call back number only
☐ Do not call me at work

WRITTEN COMMUNICATION ☐ Please check this box to receive educational marketing materials.

☐ OK to mail to my home address ☐ OTHER: ______________________

☐ OK to fax/email to my home or work fax: ____________ Email: ______________________

I request and authorize Central Florida Hearing Services (CFHS), PLLC and its staff to communicate with me and other authorized health care providers involved in my care about any aspect of my health and medical care by means of electronic mail or Facsimile.

I understand electronic mail is not appropriate for communication about all health issues, particularly those of an urgent nature, and CFHS, PLLC can make no guarantee of response within a certain time frame.

I understand that electronic mail is not encrypted and therefore not as confidential as mail or telephone communication.

I understand that it is possible for a third party, including an employer, to intercept or read electronic mail without knowledge of either the sender or recipient of the mail. Because of the ease and informality with which electronic mail may be easily rebroadcast to multiple addresses, the potential loss of confidentiality associated with its use may be of greater consequence than that suffered with written or telephone communication.

Since CFHS, PLLC does not operate or control any service on the internet, I understand CFHS, PLLC cannot and does not guarantee that use of this means of communication will be free from technological difficulties including, but not limited to, loss of message.

I understand that information communicated by means of electronic mail will be incorporated and retained within my CFHS, PLLC medical record. As a result, that information including, but not limited to my electronic mail address, may be disseminated as part of an authorized release of a copy of the medical record.
My signature below denotes that I accept the risk of loss of privacy of confidential medical information associated with communication by electronic mail and nonetheless, agree to its use. I also agree that CFHS, PLLC shall not be liable for any type of damage or liability arising from or associated with loss of confidentiality due to communication by electronic mail of faxing.

____ ______________
PATIENT SIGNATURE* DATE*

Information deemed appropriate unless updated in writing.

DISCLOSE INFORMATION TO:

Name ______________________ Relationship __________ Phone ______________

☐ Patient refused to sign ______________________________ ______________
OFFICE PERSONNEL SIGNATURE DATE

***IF YOU REFUSE TO SIGN THIS WE WILL NOT BE ABLE TO SEND ANY INFORMATION TO YOUR REFERRING PHYSICIANS VIA FAX OR EMAIL.**

Questions concerning the appropriateness of communication by means of electronic mail and faxing should be resolved prior to signing.