38135 Market Square
Zephyrhills, FL 33542

AUTHORIZATION TO COMMUNICATE PROTECTED HEALTH INFORMATION (PHI) via ELECTRONIC MEANS

PATIENT INFORMATION		
Last Name	First Name	Middle Initial
DOB	Phone#	

I AUTHORIZE FLORIDA MEDICAL CLINIC,LLC TO COMMUNICATE WITH ME VIA THE FOLLOWING ELECTRONIC MEANS:

METHOD	CONTACT INFORMATION
☐ TEXT	
☐ EMAIL	
☐ VIDEO CONFERENCE	

☐ I do not authorize Florida Medical Clinic, LLC to communicate with me via electronic means

This Authorization to Communicate PHI via electronic means expires

☐Upon written revocation ☐Other

I understand by selecting the method of communication above and signing below, I authorize Florida Medical Clinic, to share/communicate PHI information via electronic means to myself or my designated representative described above.

I understand Florida Medical Clinic may communicate to me information such as when I have an upcoming appointment, services recommended by my doctor (i.e. flu shot), medication refills, new services offered, financial information or statements and new locations/providers at Florida Medical Clinic.

I understand that according to HIPAA Privacy Rule § 164.501, Florida Medical Clinic cannot sell or distribute my communication method or information with any third-party without my prior consent.

I understand that, by federal law, the Florida Medical Clinic may not use or disclose my health information without my authorization, except as provided in Florida Medical Clinic's Notice of Privacy Practices.

I hereby release Florida Medical Clinic and its employees from any and all liability that may arise from the release of information as I have directed.

I understand emailing and texting are not secure forms of communication and I release Florida Medical Clinic from any liability.

I understand that I have the right to revoke this Authorization at any time, if I do so, it must be in writing and address it to the person or institution named above. The revocation will not apply to any information already released as a result of this authorization.

I understand that I may refuse to sign this Authorization to communicate PHI via electronic means and that I cannot be denied or refused treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

Notice of Billing Efforts Conducted Via Electronic Means

I understand that in its regular course of billing and collection efforts, Florida Medical Clinic LLC may communicate with me via electronic means and that any phone number (including cellular phone numbers) and/or email address provided to Florida Medical Clinic LLC may be used for these purposes. I consent to the use of e-mail, text or automated voicemail communication by Florida Medical Clinic, LLC if I have any balances due on my account, regardless of my Preferred Contact selection(s) for communication of protected health information (PHI) via electronic means. I understand that contacts may be made as a direct dial call or through the use of email, text messages, pre-recorded or artificial voice messages, and/or the use of an

"automated telephone dialing system" or "autodialer". I understand that message and data rates may be assessed by my mobile provider. By signing this form, you represent that you are the cellular subscriber or customary user with respect to the cellular number(s) provided and that you have the authority to provide consent..	
Signature	Date
Print Name:	Signature by: ☐Patient ☐Legal Guardian ☐Proxy ☐Legal Representative
COMPLETE ONLY IF THE PERSON AUTHORIZING COMMUNICATION IS <u>NOT</u> THE PATIENT	
Name of Representative	
Relationship to Patient (parent, health proxy, etc.)	Phone #
Email Address	