IGC

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AUTHORIZATION TO LEAVE PROTECTED HEALTH INFORMATION BY ALTERNATE MEANS

Patient Name:_____DOB:_____

(Please check all that apply):

- ☐ May leave detailed message on voicemail at home #_____
- ☐ May leave detailed message on voicemail at work #_____
- ☐ May leave detailed voice/text message on cell phone #:_____
- ☐ May leave detailed message on different phone #:_____
- ☐ May leave detailed message with family member(s) (names):_____ at the following phone #:_____
- ☐ May correspond via email (email address):_____
- ☐ **DO NOT leave any detailed message or communicate with me via voicemail on phone, text message, email, or video conferencing**

Please note that "detailed message" includes appointment scheduling, appointment reminders, and test results.

I acknowledge and understand that email or text messaging or video conferencing may not be secure communication, and that there may be some level of risk that the information in the email, text messaging, or video conferencing could be intercepted by a third party.

I also acknowledge and understand that with the authorization of messages on voicemail, other people in my household may hear the protected health information left on the voicemail message.

I further understand that Integral Gastroenterology Center, P.A., will not be responsible for any unauthorized access of my protected health information while in transmission to me via the selected above parameters. I also understand that Integral Gastroenterology Center, P.A., is not responsible for safeguarding my protected health information once it is delivered to me.

With my signature below, I acknowledge and understand that this information will be kept in my medical record, and the above parameters will be followed until revoked by me in writing. It is my responsibility to notify Integral Gastroenterology Center, P.A., should I change one or more of the telephone numbers listed above.

_____ _____
Signature of Patient/Legal Representative Date

_____
Relationship of Legal Representative to Patient