Today's Date: _____ Patient's Name _____

Consent for Treatment

By signing below, you are giving consent for treatment. This treatment may include the prescription of medication (we will discuss alternative forms of treatment and the risks and benefits of medications). Physician may also need to receive medication records from your pharmacy. Clearly, no medication would be prescribed without your specific consent for the medicine. We encourage you to ask as many questions as necessary to fully understand what to expect from taking the prescribed treatment. Since all medications have a potential for side effects, any reaction that is unusual should be reported to the prescribing physician promptly. If necessary, you may go to a hospital emergency room if the reaction is severe or life- threatening. I have had the opportunity to read this document and ask questions if desired. My signature below conveys my understanding of the terms of this document, my agreement to abide by them, and my consent to receive services.

Patient's/Legal Guardians Signature: _____

Releasing Information / Patient's Rights and Acknowledgement of Receipt of Notice of Privacy Practices

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy and is only to be used or shared in the minimum necessary fashion. Healthcare providers are to obtain their patient's consent for uses and disclosure of health information about the patient to carry out treatment, payment, or health care operations. By signing this consent, you understand that your physician may need to provide necessary medical information to other appropriate physicians, pharmacies, hospitals, insurance companies, laboratories, and billing agencies. Refusing to consent to the use or disclosure of your personal health information prohibits the doctor from billing for their services; scheduling your care for treatment; or calling in a prescription to a pharmacy; or medical need. Under this law we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke any actions that have already been taken which relied on this or a previously signed consent. If you have any objections to this form, please ask to speak with our Office Manager.
I acknowledge that I have been provided with ***MY FAMILY PHYSICIANS.,*** **"**Notice of Privacy Practices" and I am giving my consent for the use and disclosure of Protect Health Information as required and / or permitted by law.

Patient's/Legal Guardians Signature: _____

Text Message, Voicemail and Email Communication Consent

Your health care is important to us. In order to provide you with the best possible care, we send convenient text messages, email and voicemail messages to our patients for appointment reminders, occasionally we may send information about our product and services. **Purpose:** This form is used to obtain your consent to communicate with you by email/mobile text messaging regarding your Protected Health Information. **MY FAMILY PHYSICIANS., (MFP)** offers patients the opportunity to communicate by email/Voicemail and mobile text messaging. Transmitting patient information by email/Voicemail and mobile text messaging has a number of risks that patients should consider before granting consent to use email/Voicemail and mobile text messaging for these purposes. **MFP** will use reasonable means to protect the security and confidentiality of email/mobile text messaging information sent and received. However**, MFP** cannot guarantee the security and confidentiality of email/Voicemail and mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

If you wish to change your preferences or if you wish to decline receiving all text messages, emails or voicemail messages from **MFP**, please advise our office in writing. We look forward to providing better and more convenient communications with you. Our goal is to provide you with relevant and useful information about your health care and the products and services we offer for improving your health.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email/mobile text messaging between **MFP** and me and consent to the conditions outlined herein. Any questions I may have had were answered. My consented email address is: _____.

In Case of Any Emergency Please Call 911 or Proceed to the Nearest Emergency Room, DO NOT USE THIS WAY OF COMMUNICATION FOR THAT PURPOSE.

Patient's/Legal Guardians Signature: _____

Patient Request for Confidential Communications of Protected Health Information

The Health Insurance Portability Act of 1996 ("HIPAA") provides you the right to request that **My Family Physicians., (MFP)** communicate with you about your health information at an alternative address, email, phone number, or by an alternative means of your choice that is more confidential for you. Be aware that transmitting patient information by e-mail has a number of risks that patients should consider before granting consent to use e-mail for these purposes. **MFP** will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, **MFP** cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information. **MFP** must accommodate your request if it is reasonable. **MFP** may require you to specify an alternative address or other method of contact before providing the requested accommodation. If your request is accepted, the Medical Center will make every attempt to communicate with you in the manner you have requested. Your election will remain in effect until you have instructed us in writing to change the manner of communication.
If email, address or phone number is different than what we have on file form please specify here:
_____

*I acknowledge that I have read and fully understand this consent form, including the risks associated with communication via e-mail and consent to the conditions outlined herein. I agree and consent that **MFP** may communicate with me regarding my protected health information by alternate means that is more confidential for me including email and text messages.*

Patient's/Legal Guardians Signature: _____