AdventHealth
Centra Care

COMMUNICATION AUTHORIZATION

Center for Employee Health (Practice) would like to communicate with you in the ways you prefer. **By signing below, you allow us to disclose your protected health information (PHI) as described on this form.** PHI includes all information regarding your treatment and care. We may need to contact you for a number of reasons, including to provide information about your treatment or payment for your care. *We may use and disclose your PHI in other ways if it is permitted by law and we determine such disclosure to be necessary under the circumstances.* Once your information is disclosed as permitted by this form, it may be re-disclosed by the recipient and federal laws will no longer protect it.

Patient name: _____

Street address: _____ City, state, zip: _____

Date of Birth: _____ Today's date: _____

I hereby request the following regarding the use and sharing of my PHI:

1. **Telephone messages:** We may leave messages on answering machines or with individuals answering the phone at the numbers written in this section, including referral information, prescription refill reminders, appointment reminders, test results, and other information the Practice determines to be appropriate to leave on voice mail or with the person answering the phone. Please write the number(s) you would like us to use on the line below or, if you do not want us to leave messages, write "none" or leave this blank:

_____

List all phone numbers, including area code, where the Practice may leave messages, if applicable.

2. **Sharing PHI with family and friends:** In addition to any individuals who may be handling messages left as allowed in section 1 above, or individuals we may contact in emergencies or as otherwise allowed by law, you allow us to discuss PHI with the following family members, friends, or other individuals you list below and on any additional sheet attached to this form:

Printed name	Printed name
Street address	Street address
City, State, Zip	City, State, Zip
Phone number, including area code	Phone number, including area code

Emails and Texting: Sending your PHI by unencrypted email, texting, or wireless calls carries risk. Most standard forms of email and texting do not provide a secure means of communication. There is a risk that PHI contained in an unencrypted message may be disclosed to, or accessed by, unauthorized individuals. They may be lost or misdelivered. Use of more secure communications, such as by regular telephone, is always an alternative that is available to you. If you do not receive a response to an email or text sent to the Practice, always call or write instead. If you agree to accept these risks, please indicate below how you would like us to communicate with you.

3. **Email Communication**: If you allow us to use your PHI to communicate with you by email at the address you have written on this form, including sending breach notices and other messages, please neatly print the address here: _____

4. **Calls and Texting:** You consent to receive treatment and account-related calls from the Practice at the following numbers: landline:_____, mobile:_____.

(Note: to receive calls/texts to your cell phone, you must complete the below opt-in)

CONSENT FOR AUTODIALED AND/OR ARTIFICIAL OR PRERECORDED CALLS AND MESSAGES

By providing your cell phone number, you expressly consent to receiving calls and/or SMS/text messages on your cellular device, placed by Florida Hospital, its affiliates, business associates, and/or its service providers, from an automatic telephone dialing system and/or using an artificial or prerecorded voice. Standard data rates may apply These calls and messages will be for marketing and/or health care and related purposes including, but not limited to, for the purpose of informing you of and/or advertising health updates, health events, health products and services, general health and wellness information, appointment and refill reminders, office closure announcements, and treatment, and/or for the purpose of servicing your account, payment and billing, and collecting any amounts you may owe.

Opt-In

I, (*print name*)_____, expressly consent to receiving calls and/or SMS/text messages on my cellular device at (*print cell number*)_____, from Florida Hospital, its affiliates, business associates, and/or its service providers, from an automatic telephone dialing system and/or using an artificial or prerecorded voice, for the purposes described above. I agree to notify Florida Hospital immediately if I change or obtain a new cell phone number, or no longer maintain the cell phone number provided in this provision.

_____ _____

Signature Date

Help or Support: If at any time you need additional information or information on how to stop text messages, reply to any text message we sent to you and send a text message with the keyword HELP to the number used to send the message, or call us at 1-800 xxx-xxxx. We can answer any questions you may have regarding the program. To stop text messages, just text STOP to the number used to send the message.

Even if you do not choose to receive autodialed and artificial or prerecorded voice calls and/or SMS/text messages for purposes of collecting amounts owed on your account, this election applies only to those calls or messages to your cellular device, Florida Hospital reserves the right to, and you expressly agree that Florida Hospital, its affiliates, business associates, and/or its service providers may, contact you by email or by telephone at any non-cellular telephone number associated with your account for all lawful purposes, including those described above.

5. Sensitive Conditions: We may discuss sensitive conditions directly with you, either in person, by mail, or over the phone. If you allow us to disclose PHI regarding certain sensitive conditions, including, but not limited to HIV/AIDS, substance abuse, mental health or conditions, genetic testing, sexually transmissible diseases and tuberculosis by email, telephone messages, or wireless calls and texting as described on this form, please initial here: _____.

Do not use emails or texting to communicate with us regarding urgent or time-sensitive matters. In a medical emergency, call 911.

It is your responsibility to make sure that only authorized people are allowed to access your email, phone messages, and mobile devices. If individuals other than you receive your PHI sent in the ways allowed on this form, they may share it with others and state and federal privacy laws will not protect it.

You can revoke this form by sending a written notice to us at **831 Simpson Rd, Suite 102, Kissimmee, FL.** The revocation does not apply to the extent we have already acted on your written permission.

By signing below, you agree that this document is effective until you provide a new form, tell us in writing that you revoke it, or 5 years after you are no longer a patient of the Practice, whichever is sooner. You do not have to sign this form. If you do not sign, it will not affect the way we treat you or your eligibility for benefits. We will still communicate with you in person, by telephone, by mail, and as otherwise allowed by law.

_____ _____

PATIENT NAME PRINTED DATE

_____

PATIENT/LEGAL REPRESENTATIVE SIGNATURE

_____

Legal representative printed name and description of relationship (if applicable)

Provide the patient with a copy of this form.