Town & Country Pediatrics
3009 N. Ballas Road, Suite 131A
Town & Country, MO 63131
Office (314) 994-0209
Fax (314) 994-9130

Due to the federal privacy regulations, we cannot leave messages with protected health information on home answering machines or with family members without written permission.

Patient name: _____

Home phone#: _____ Cell phone#: _____

Other #: _____

****Please indicate which above phone number is the preferred contact method****

I give Town & Country Pediatrics, PC permission to leave messages

_____ On my home answering machine/voice mail

_____ On my cell phone voice mail

_____ With the persons listed (name and relationship)

_____

_____

_____ I do not want medical information released except personally to myself.

_____
Signature

Town & Country Pediatrics, PC

OPEN AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I, _____ hereby authorize **Town & Country Pediatrics, PC** to release any and all Protected Health Information (PHI) maintained in my Medical Record to the following individuals, concerning my status as a patient, treatment or payment services provided by **Town & Country Pediatrics, PC**

NAME	Relationship to Patient
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

This authorization is given freely with the understanding that:

1. This authorization is valid until revoked by me.
2. I may revoke this authorization at any time, except where information has already been released, by completing Town & Country Pediatrics, PC's Revocation of Authorization Form.
3. Individuals listed on this form will be able to receive any and all information related to my status as a patient, treatment or payment of services provided to me by Town & Country Pediatrics, PC during the time period in which this authorization is valid.
4. Individuals not listed above will be unable to receive any information regarding treatment or payment for services provided to me without my prior written authorization.
5. Town & Country Pediatrics, PC and its workforce members are hereby released from any legal responsibility or liability for disclosure of any of my Protected Health Information as indicated and authorized herein.

_____ _____

Signature Date

_____

Witness

For office Use only

Date of Receipt		Signature	

Town & Country Pediatrics, PC

EMAIL CONSENT

Email information will be added to our private email account for office updates/Immunization/Scheduling reminders only.

PRIMARY EMAIL ADDRESS:
ALTERNATE EMAIL ADDRESS (optional)

	Please check the box if you would like to sign up for our patient portal. A link will be emailed to you to create a log in and password.
The patient portal will give you access to immunization records, show any appointments scheduled-request to schedule appointments, update your records.	

HIPAA EMAIL CONSENT

- HIPAA stands for the Health Insurance Portability and Accountability Act
- HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information
- Information stored on our computers is encrypted
- Most popular email services (Hotmail, Gmail, Yahoo) do not utilize encrypted email
- **When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it.**
- Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA
- The information is available in a pdf (page 5634) on the U.S. Department of Health and Human Services website http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf
- The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email.

OPTION 1 – **ALLOW** UNENCRYPTED EMAIL

I understand the risks of unencrypted email and do hereby give permission to Town & Country Pediatrics, PC to send me personal health information via unencrypted email.

_____ _____ _____

Signature Printed Name Date

OPTION 2 – **DO NOT ALLOW** UNENCRYPTED EMAIL

I do not wish to receive personal health information via email

_____ _____ _____

Signature Printed Name Date