**PHONE CONSENT FOR PHONE COMMUNICATION**

We, at **Tran-Vo, PLLC Family Practice**, are committed to safeguarding the privacy and confidentially of your medical records including the personal information that you have with us. We comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

From time to time it may be necessary or desirable to contact patient by phone. To expedite your health care and in the interest of convenience, if you are not available to speak with us directly, we would like to leave a message whenever possible or confirm appointments.

To assist us in protecting your privacy, please complete the following:

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_

**I WISH TO BE CONTACTED IN THE FOLLOWING MANNER: (CHECK ALL THAT APPLY)**

Home Phone Cell Phone

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Leave a detailed voicemail message?  Yes No

Leave a message with call back number? Yes No

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Leave a detailed voicemail message? Yes No

Leave a message with call back number? Yes No

May we speak to someone else regarding your medical care? Yes No

Name of person: Relationship:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT CONSENT FOR**

**USE OF EMAIL COMMUNICATIONS**

To better serve our patient, **Tran-Vo, PLLC Family Practice** has established an **unencrypted email address** for some forms of communication. For non-urgent matters that do not require immediate response, please feel free to contact us at  **[tranvoclinic@gmail.com](mailto:tranvoclinic@gmail.com).** However, please remember this form of communication is not appropriate for use in an emergency.

**RISKS**

Communication by **unencrypted email** has a number of risks which include, but are not limited to, the following:

* Email can be circulated, forwarded and stored in paper and electronic files.
* Backup copies of e-mail may exist even after the sender or the recipient has

deleted his/her copy.

* Email can be received by unintended recipients.
* Email can be intercepted, altered, forwarded or used without authorization or

detection.

* Email can be used to introduce viruses into computer systems.

**You should not communicate with our practice through our unencrypted email if any of the above risks concern you.**

**GUIDELINES FOR EMAIL COMMUNICATION**

* Include the general topic of your message in the subject line of the email (e.g. appointment).
* Include your name, date of birth, and phone number in the body of the email

The content of the email should only be used for non-sensitive and non-urgent issues. The email message should also not be time sensitive. Tran-Vo, PLLC Family Practice endeavor to read and respond within 48-72 hours to any email. However, we cannot guarantee that any email will be responded to within any particular time.

HIPAA 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.

I acknowledge that I have read and fully understand this consent form. I understand and agree to give my consent for email communications with Tran-Vo, PLLC Family Practice.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_