Patient's Name:

Patient Confidentiality and Treatment of Private Medical Information

Please list people (and their relation to you) to whom we may release information about your medical condition and/or treatment. Please include anyone who may pick up prescriptions, reports, x-rays, etc. for you.

Name:

First Name Last Name

Relationship to Patient:

Name:

First Name Last Name

Relationship to Patient:

Name:

First Name Last Name

Relationship to Patient:

How can we communicate confidential information (e.g., lab results, referrals, diagnostic test results, billing inquiries, appointment reminders)? *Please see Email & standard SMS Messaging Consent below.*

Home/Cell Phone?

Is it permissible to leave voice messages or messages with other people who may answer the telephone?

Work Phone?

Patient's Name:

Is it permissible to leave voice messages or messages with other people who may answer the telephone?

Notice of Privacy Practices Acknowledgment

By signing below, you acknowledge that you have received the Notice of Privacy Practices and you consent to the use and disclosure of your medical information except as expressly stated below. You understand that Adjuva Primary Care has the right to change its Notice of Privacy Practices and that you may contact Adjuva Primary Care at any time if you have any questions.

I hereby request the following restrictions on the use and/or disclosure of my information. I understand that you are not required to agree to my requested restrictions and will notify me, in writing, if my request(s) is denied.

Patient Signature:

Name:

First Name Last Name

Date:

Appointment reminders:

Yes, I choose to receive appointment reminder text messages.
No thanks, I do not want to receive appointment reminder text messages.

Other Email &/or Standard SMS messaging communication:

Yes, I choose to participate in additional email &/or standard SMS messaging communication.
No thanks, I choose not to participate in additional email &/or standard SMS messaging communication.

Patient's Name:

By selecting yes, *I hereby consent and state my preference to have eClinicalworks dba Adjuva Primary Care communicate with me by email or standard SMS messaging regarding various aspects of my medical care, which may include, but shall not be limited to, test results, prescriptions, appointments, and billing. I understand that text messages are not a substitute for professional or medical attention.*

I understand that email and standard SMS messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS messaging regarding my medical care might be intercepted and read by a third party.

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Patient Name *

First Name Last Name

Date of Birth *

Signature of Patient *

Date *