

**AUTHORIZATION to Use or Disclose Protected Health Information
Email Correspondence or Electronic Media**

Patient Name	Verification of Identity (Driver's License, ID Card, Passport, etc.)	
Address	Date of Birth	Medical Record Number

** Complete the following only if the person authorizing the use or disclosure is not the patient:

Name	Relationship to Patient	Legal Authority
Verification of Identity	Verification of Authority	Witness Signature

By signing this form, I authorize:	<i>Person, class of persons, or organization</i>	
to communicate with me and with other health care providers as necessary for my / the patient's medical care and treatment via:	<input type="checkbox"/> E-Mail	
	Patient's Email Address:	Caregiver's Email Address:
	<input type="checkbox"/> Video Teleconference <input type="checkbox"/> Audio Teleconference Other Electronic Media: (Describe) _____	

I understand that the following types of protected health information may be used, disclosed, and retained by the health care providers as a result of the communications: *(Check all that are approved.)*

- My personal health information contained in emails**
- Video or electronic Diagnostic Images (x-rays, MRIs, CT Scans), Laboratory Test results, Pathology reports; and other diagnostic test results**
- Video recordings (sound and picture) of parts of my body that may include my face**

I further authorize the disclosure of the following information which may be included in the protected health information listed above. *(Check all that are approved.)*

- Mental Health**
- Substance Abuse**
- HIV/AIDS**

I have read and understand the Alert for Electronic Communications and agree that e-mail messages and teleconferences may include protected health information about me / the patient, whenever necessary.

I understand that, by federal law, the University of Florida may not use or disclose my health information, except as provided in the University's Notice of Privacy Practices, without my authorization. My signature on this Authorization indicates that I am giving permission for the uses and disclosures of the protected health information described above. I hereby release the University of Florida and its employees from any and all liability that may arise from the release of information as I have directed.

I understand that I have the right to revoke this Authorization at any time. If I want to revoke this authorization, I must do so in writing and address it to the person or institution named above that I am authorizing to disclose my information. I understand that if I revoke this authorization, it will not apply to any information already released as a result of this authorization.

I understand that I may refuse to sign this Authorization. I also understand that I cannot be denied or refused treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign this Authorization.

I understand that, once information is disclosed pursuant to this Authorization, it is possible that it will no longer be protected by the federal medical privacy law and could be disclosed by the person or agency that receives it.

This authorization expires automatically upon: **No Expiration Date** **Other:** _____
Date or Event

I have read and understand the information in this authorization form.

Signature of Patient or Legal Representative: _____ *Date*

Alert for Electronic Communications

1. E-Mail Correspondence:

a. Patients and/or personal representatives who want to communicate with their health care providers by e-mail should consider all of the following issues before signing an Authorization to Use or Disclose Protected Health Information via Electronic Media:

- 1) E-mail at the University of Florida can be forwarded, intercepted, printed and stored by others.
- 2) E-mail communication is a convenience and not appropriate for emergencies or time-sensitive issues.
- 3) Highly sensitive or personal information should not be communicated by e-mail (i.e., HIV status, mental illness, chemical dependency, and workers compensation issues.)
- 4) Employers generally have the right to access any e-mail received or sent by a person at work.
- 5) Staff other than the health care provider may read and process e-mail.
- 6) Clinically relevant messages and responses will be documented in the medical record.
- 7) Communication guidelines must be defined between the clinician and the patient, including, (1) how often e-mail will be checked, (2) instructions for when and how to escalate to phone calls and office visits, and (3) types of transactions that are appropriate for e-mail.
- 8) E-mail message content must include (1) the subject of the message in the subject line, i.e., prescription refill, appointment request, etc., and (2) clear patient identification including patient name, telephone number and patient identification number in the body of the message.
- 9) The University of Florida will not be liable for information lost or misdirected due to technical errors or failures.

b. The following confidentiality statement is recommended for inclusion in all e-mails between patients and physicians:

NOTE: This communication may contain information that is legally protected from unauthorized disclosure. If you are not the intended recipient, please note that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this message in error, you should notify the sender immediately by telephone or by return email and delete this message from your computer.

2. **Video and Audio Conferences:** Patients and/or personal representatives who participate in teleconferences with their health care providers should consider all of the following issues before signing an Authorization to Use or Disclose Protected Health Information via Electronic Media:

- a. Although interactive video and audio teleconferences use equipment and telecommunications lines which have been approved for secure use by the Health Science Center Information Technology Department, complete privacy and security cannot be guaranteed.
- b. Pertinent personal information, including HIV status, mental illness, chemical dependency, substance abuse, developmental, genetic, and workers compensation issues will be communicated during the teleconference.
- c. Staff other than the health care provider may have access to the teleconference recordings and transmissions.
- d. The University of Florida will not be liable for information lost or misdirected due to technical errors or failures.