SPOKANE FOOT CLINIC

Release of Information / Electronic Communication Consent Form

By signing this form, you are acknowledging and agreeing to comply with the following:

-To send and receive medical information electronically to/from Spokane Foot Clinic using the email and cell phone number listed below.

-I grant access for my medical information to be shared with the individual(s) and facility listed below.

-Medical information can include appointment details, billing and claim records, discussion of treatment plans, medical records, operative reports, x-ray reports, progressive reports, and lab results.

-I acknowledge I will not send any pictures related to my care, and if I do, I am aware it will not be used to assess a current condition.

-I acknowledge messages can take up to 48 hours to respond to, and in the event of a medical emergency I will contact 911.

-I acknowledge that email and cell phone messaging is not a guaranteed or secure way of sending and receiving information. You may not hold Spokane Foot Clinic responsible for any breach of confidentiality that results from the email, cell phone number, or persons listed below.

I hereby authorize Spokane Foot Clinic and Northwest Surgery Center to disclose my protected health information as described above. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it. I understand that I may revoke this authorization at any time by giving notice in writing at the address found above, but if I do it will not affect any actions taken before receipt of my revocation. I understand that my treatment will not be conditioned on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Patient's Name: _____ DOB: _____

Patient's Signature: _____ Date: _____

Email Address(s):

_____

Cell Phone Number: _____

Persons/Facility to share Information: _____

Specific Authorization: I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information.

Signature: _____ Date: _____

This release of information for the above persons/facility will expire on _____