***Electronic Communications Agreement for Personal Health Information***

*This Electronic Communications Agreement for Personal Health Information (PHI Agreement) is entered into between Pandora Family Medicine ("Private Practice") and the undersigned patient ("Patient").*

*This agreement outlines the terms and risks related to using email, text, video calls (e.g., FaceTime, Skype) and other electronic communication methods that may involve the exchange of Protected Health Information (PHI).*

**Please initial each item and sign at the end.**

\_\_\_\_\_ **I authorize** Pandora Family Medicine to use email, text, or video platforms (e.g., Skype, FaceTime) for communication, which may include PHI. **I understand** these platforms may not guarantee privacy, though the practice will make reasonable efforts to protect my information.

\_\_\_\_\_ **I agree** to provide and keep updated my current mobile number, email, and other electronic contact information. **I authorize** the practice to respond to communications that appear to come from me, even if not from my official contact information.

\_\_\_\_\_ **I understand** that electronic communication is not appropriate for emergencies or urgent matters. **I will call 9-1-1 or go to the nearest emergency room in such cases.**

\_\_\_\_\_ **I acknowledge** that Pandora Family Medicine values my privacy, takes reasonable security measures, and complies with HIPAA/HITECH standards in handling electronic communication.

\_\_\_\_\_ **I understand** that technical failures, hacking, or theft could compromise my PHI. **I still authorize** electronic communication and agree to hold harmless Pandora Family Medicine and its staff for unintended disclosures not directly caused by the practice.

\_\_\_\_\_ **I authorize** the practice to share my PHI as needed to coordinate care, schedule services, and communicate with other providers involved in my care.

**\_\_\_\_\_ I identify** the following individuals or entities as authorized to receive my PHI:

Authorized individuals/entities (write in):

\_\_\_\_\_ **I understand** that failure to follow this agreement may result in Pandora Family Medicine terminating electronic communication with me and possibly terminating care.

\_\_\_\_\_ **I consent** to the use of electronic and after-hours communication, including those with the parties identified above.

\_\_\_\_\_ **I understand** that while convenient, electronic communication is not foolproof, and occasional privacy breaches or delays may occur. Despite this, **I authorize** the use of these methods under the terms described.

\_\_\_\_\_ **I have received** the practice’s Notice of Privacy Practices and acknowledge receipt.

\_\_\_\_\_ **I understand** I can request a copy or summary of my PHI. While basic access and storage are not subject to fees, costs may apply for:

* Skilled technical time spent preparing records
* Copying/scanning/burning records to media (e.g., CD or USB)
* Preparation of summaries or explanations
* Physical media or mailing supplies

**I agree to pay for actual costs associated with physical media or special requests.**

\_\_\_\_\_**I understand** that this agreement will remain in effect until revoked in writing by either party, with 30 days’ notice. **Revocation means electronic communication will no longer be used except as allowed by law.**

***A photocopy or digital copy of this signed form shall be considered as valid as the original.***

**Patient Name (Print):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***(or Guardian if patient is a minor)***