Patient Authorization for Emailing & Texting PHI

PursuitPT Texting/Email Informed Consent

Sending Protected Health Information (PHI) by unencrypted email or text exposes a patient's protected health information (PHI) to risks, including but not limited to:

- The email/text message could be captured electronically in transit to or from the patient if not secured.
- The email/text message could be captured electronically when at rest on an unencrypted device.

HIPAA requires that we take reasonable steps to protect against these risks but acknowledges that a balance must be struck between the need to secure PHI and the need to ensure that clinicians can efficiently exchange important patient care information with or about the patient.

The Use of Email and Text Messaging Communication to and from Patients

If you prefer that we communicate protected health information via text or email, we will need prior authorization to do so. We have listed communication options that can be selected by initialing the applicable line. You are not required to authorize the use of unencrypted email or text messaging, and a decision not to sign this authorization will not affect your health care in any way. If you prefer not to authorize the use of unencrypted email or text messaging, we will continue to use U.S. mail or telephone to communicate with you.

By opting into this form, you are providing consent for PursuitPT to send you text messages. Text messaging frequency varies. Standard message rates may apply. You can reply HELP at any time to learn more. You may opt-out anytime by replying STOP.

I authorize the use of the following non-in-person methods when communicating protected health information (PHI) with me or my authorized representative (initial all that apply):

________ Email address that may be used to send PHI:______________________________
Initials

________ Phone number for texting PHI messages:_________________________________
Initials

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Printed Name of Patient: ____

Signature of Patient: __________________________________ Date: _______________

Printed Name of Authorized Representative: _____________________________________

Relationship of Representative to Patient: ______________________________________

For help or questions regarding this form, please contact the person below:

David Lucas
Email: compliance@pursuitptin.com
Phone: 219–310–8366
Address: PO Box 458, Crown Point, Indiana 46308

Link to privacy policy and terms and conditions: https://pursuitptin.com/notice-of-privacy-practice