AUTHORIZATION AND CONSENT TO TRANSMIT PROTECTED HEALTH INFORMATION AND ELECTRONIC PROTECTED HEALTH INFORMATION VIA UNSECURED TEXT MESSAGE OR INTERNET/EMAIL

Patient's Name: _____ **Date of Birth:** _____

I, _____, expressly request, authorize, direct, permit and unequivocally consent to Jollyville Pediatrics to transmit my Protected Health Information ("PHI") and Electronic Protected Health Information ("ePHI") to me via unsecured text message/Internet/email. I expressly and unequivocally acknowledge that Jollyville Pediatrics does not have the capability to send text messages/emails in an encrypted or secured format. I expressly and unequivocally waive any claims or rights with respect to transmission of ePHI or PHI via unsecured text messages/email. I fully understand that third parties may attempt to or actually access, use and disclose PHI or ePHI transmitted by Jollyville Pediatrics to my cellular phone via text message/email or computer via email. I fully understand the risks of transmitting unencrypted text messages/email containing ePHI, I am willing to accept those risks. I knowingly, intentionally and voluntarily waive all rights, claims and damages relating to the negligence, breach of confidentiality or other tort and all other legal claims that could be asserted against Jollyville Pediatrics or any of its employees, agents, members or otherwise as a result of any third person improperly accessing, using or disclosing my PHI or ePHI as a result of transmission via unsecured text messaging, Internet or email. I intend to be legally bound hereby.

Cell Phone Number: _____

Email Address:_____

_____ _____ _____

Signature of Patient, Patient Representative or Legal Guardian | Date | Relationship to Patient