Drs. McClain & Schallhorn, P.C.

PATIENT AUTHORIZATION TO DISCUSS AND RELEASE PROTECTED HEALTH INFORMATION WITH OTHER INDIVIDUALS

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) prohibits this office from discussing a patient's care and/or account information with other individuals. For this reason, your permission is needed if you want your medical and/or account information to be disclosed to another party. Once such permission is given, this permission will remain in effect until revoked in writing by the patient or guardian.

I, ___________________________________, hereby authorize Drs. McClain & Schallhorn, P.C. and staff to contact and discuss my medical and/or financial information with the following person(s):

Name:	Relationship:	Phone Number:	Medical:	Account:
________________________	_________________	_______________________	Y / N	Y / N
________________________	_________________	_______________________	Y / N	Y / N
________________________	_________________	_______________________	Y / N	Y / N
________________________	_________________	_______________________	Y / N	Y / N

Signed by:

____ _________________________

Patient/Guardian Name Date of Birth

____ __________________________

Patient/Guardian Signature Date

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CONSENT FOR USE OF E-MAIL COMMUNICATION

In an effort to communicate in a more timely and efficient manner, Drs. McClain & Schallhorn, P.C. may utilize unencrypted e-mail for messages, including radiographs, to your referring and/or treating Dentists and Physicians.

Drs. McClain & Schallhorn, P.C. and staff will use reasonable means to protect the security and confidentiality of E-Mail information sent and received. However, communication sent over an unencrypted e-mail system may not be secure and there is no assurance of confidentiality of information when communicated this way. Drs. McClain & Schallhorn, P.C. cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information. Thus, patients must consent to the use of e-mail for patient information.

I acknowledge that I have read and fully understand the Consent for Use of E-Mail Communication form. I understand the risks associated with allowing the communication of e-mail amongst my Providers. **I AGREE** to allow Drs. McClain & Schallhorn, P.C. and/or staff to communicate via e-mail to my referring and/or treating Dentists and Physicians.

_______________________________ __________________________

Patient/Guardian Name Date

____

Patient/Guardian Signature

_____ **I do NOT** wish for Drs. McClain & Schallhorn P.C. and/or staff to communicate via e-mail with my referring and/or treating Dentists and Physicians.