PEDIATRIC DERMATOLOGY
8315 WALNUT HILL LANE #135
DALLAS, TX 75231

Email, text messaging and voice mail consents:

Email and text messaging allows health care providers to exchange information efficiently for the benefit of our patients. At the same time, we recognize that email and text messages are not a completely secure means of communication and that the information sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the internet. In addition, once the email is received by you, someone may be able to access your email account. As email is a very popular and convenient way to communicate, the federal government has provided HIPPA guidelines on email use. The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email.

Similarly, detailed voice mail messages allow clinicians to provide test results, medical and referral information to you in a timely manner but if the voice mail system is shared, the information could be heard by others.

If you would like us to send you email and/or text messages or leave detailed voice mails that contain your health information, please check the appropriate boxes and sign this consent below. You are not required to authorize the use of email, voice mail and/or text messaging. 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 email, voice mail and/or text messaging we will continue to use U.S. mail or telephone to communicate with you.

____ I understand the risks of unencrypted email and do hereby give permission to Pediatric Dermatology to send or receive personal health information via unencrypted email

____ I do not wish to send or receive personal health information via email

Please read and authorize the use of the following communication methods when communicating with me and my authorized individual (check all that apply)

_____ Email address that may be used to send information to you: _____

____ Phone number to send text messages to you: _____

____ Phone number for detailed voice mail to you: _____

Name of Patient: _____

Signature of Parent/Legal guardian: _____ Date _____

Relationship to Patient: _____

Texas Medical Association
Physicians Caring for Texans

The Physicians Foundation

Telemedicine Informed Consent
Pediatric Dermatology of Dallas, PA

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
   a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
   a. I may revoke my right at any time by contacting Pediatric Dermatology of Dallas, PA at 214-580-1011.
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
   a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
   b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.

c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.

7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

_____	_____
Patient/Parent/Guardian Printed Name	Patient/Parent/Guardian Signature
_____	_____
Witness Signature	Date

TMA gratefully acknowledges the Texas Medical Association Special Funds Foundation for its support of this document through funds awarded by The Physicians Foundation.