Request for E-mail/Fax Disclosure of PHI

Four Seasons Pediatrics
532 Moe Road
Clifton Park, NY 12065
Phone: 518-383-2425 / Fax: 518-383-3255
Email form to:
exchange@fourseasonspediatrics.com

You have chosen to request that personally identifiable information (PHI) concerning your child/children/yourself be disclosed by fax or email without the use of encryption. Sending PHI via unencrypted e-mail or by fax has some risks that you should be aware of prior to giving your authorization. These risks include, but are not limited to:

- Unencrypted e-mail sent over the internet is not secure and can be intercepted by unknown third parties.
- E-mail content can be changed without the knowledge of the sender or receiver.
- Back up copies of e-mail may still exist even after the sender and receiver have deleted the messages.
- There is no assurance of confidentiality of information communicated via e-mail or fax.

Parent Acknowledgement and Agreement:
I acknowledge that I have read the above risks and understand there may be further risks involved by using fax or e-mail to receive/send PHI.
I acknowledge and understand that receiving/sending by fax or over the internet or using unencrypted e-mail may not be secure and there is no assurance of confidentiality of information sent by these methods.

☐ I authorize Four Seasons Pediatrics to send/ receive PHI via the e-mail/ fax number below to me regarding my child/children/myself named below.
☐ For the future I authorize Four Seasons Pediatrics to send/receive PHI via the email or fax to the listed party whenever verbally requested.

Patient Name/ DOB	School / Facility	Fax # or email address	Check for Nurse
_____	_____	_____	☐
_____	_____	_____	☐
_____	_____	_____	☐
_____	_____	_____	☐

Information being requested _____

Duration: This authorization will become effective immediately and shall remain in effect for one year from the date of signature. Unless specified by dates or defined event: _____.
Revocation: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received. Written revocation may be addressed to: Privacy Officer, Four Seasons Pediatrics 532, Moe Road Clifton Park, NY 12065.

_____ _____
Print Name Relationship to child/ children

_____ _____
Signature Date

**** Please note – this form is for releasing PHI from the medical record or forms. For communication with your provider, the nurse or other staff members please use the patient portal or call by phone.**