Dr. Rachel Bailey, DC
3839 Bee Caves Road, Suite 206
Austin, TX 78746
512-585-4654

Date: _____

I, _____ hereby authorize Dr. Rachel Bailey, DC to use the following
(Patient Name)
methods of communication to release personal health information. (Please initial each line for communication you wish this office to use.)

_____ Voicemail _____ SMS/Text Message _____ Fax _____ Email*see below

Email: **VERY IMPORTANT! PLEASE READ!**

- Most popular email services (ex. Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email
- When we send you an email, or you send us an email, UNLESS it is sent through Dr. Bailey's ShareFile Account, the information that is 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 and read it.
- HIPAA 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

OPTION 1 – ALLOW UNENCRYPTED EMAIL
I understand the risks of unencrypted email and do hereby give permission to send me personal health information via unencrypted email.

_____
Signature Date Printed name
(parent or guardian if patient is a minor)

_____
Please print email address

OPTION 2 – DO NOT ALLOW UNENCRYPTED EMAIL
I do not wish to receive personal health information via email.

_____
Signature Date Printed name
(parent or guardian if patient is a minor)