Consent and Release of Information

If under 18 years of age, you must have a parent or guardian sign below*

- I voluntarily agree to treatment including but not limited to diagnostic tests, procedures and/or treatments or other modalities by which the attending provider has deemed necessary and of which are administered to or to be performed on me under the direction of the attending provider and his/her designee.
- I allow Pinon Family Practice to access my medication history via electronic download from all local pharmacies and CORHIO – CO Regional Health Information Exchange. I undstand that I am able to opt-out by request.
- I understand that if a controlled substance is being provided to me, limited information will be submitted into Colorado Prescription Drug Monitoring Program for limited purposes allowed under Colorado Law.
- I understand that vaccinations received will be entered into the Colorado Immunization Information System (CIIS). I undstand that I am able to opt-out by request.
- I understand that it may be necessary for other healthcare providers to review information in my medical records in order to render medical care to me. I authorize Pinon Family Practice to discuss with and/or to copy all or part of my medical record in the event that it be needed by another provider to provide treatment.

[ ] **I acknowledge my understanding of the above Consent to Release Information and have a chance to ask questions and received answers.**

Initial

Release of My Personal Information

Please select and complete each section

I authorize the release of information including the diagnosis, visit information, diagnostic and test results and claims/billing information rendered to me. *(Pleaes note: previously providing an "Emergency Contact" does not give authorize our PFP to give access to your PHI - you must list an indivual below)*

***This information may be released to:** **(Please provide first and last name)**

[ ] Spouse: Phone:

[ ] Children: Phone:

[ ] Other: Phone:

[ ] Information is not to be released to anyone *(if nothing else is selected, we will select this option for you)*

[ ] **I acknowledge that this Release of Information will remain in effect until terminated by me in writing.**

Initial

Acknowledgement and Receipt of Notice of Privacy Practices

- Pinon Family Practice's Notice of Privacy Practices is available on our website (www.pinonfamilypractice.com), on the bulletin board in our waiting room and at the front desk, please ask a receptionist if you need assistance.
- The undersigned Patient or legally authorized representative ("Agent") of the Patient acknowledges that he or she personally received a copy or was offered a copy of Pinon Family Practice, LLP's Notice of Privacy Practices on the date indicated below .
- I agree that a photocopy or digital image of this agreement shall be as valid as the original.

Patient Name: **DOB:**

***If under 18 years of age, you must have a parent or guardian sign below.**

Signature of Patient, Guarantor or Agent: **Date:**

Information about the "Agent" (attach appropriate documentation) or Guarantor – *please print*

Agent/Guarantor:_____ Title/Relationship:_____

Patient Portal - Informed Consent

Pinon Family Practice does not have secure, HIPAA compliant email and use of the Patient Portal is highly encouraged for patients 18+. PFP does not allow portal access for patient 13-18. When using the portal, you are responsible for taking steps to protect yourself from unauthorized use of online communications, such as keeping your username and password confidential. Pinon is not responsible for breaches of confidentiality caused by you or an independent third party. You agree to take steps necessary to keep your Patient Portal and subsequent medical information confidential including:

Signing up for and consenting to use of the Patient Portal, you agree to accept messages, results and any other notifications deemed appropriate by PFP in lieu of phone messages and will accept the terms and conditions outlined in the Patient Portal sign-in process. Such messages will be sent by Providers and/or staff of Pinon Family Practice.

Do not download or store your personal information on your employer-provided computer; otherwise personal information could be accessible or owned by your employer.

Use screen savers or close your portal instead of leaving your open chart on the screen for passersby to read and keep your password safe and private.

Do not allow other individuals or other third-party access to the computer(s) upon which you store your personal medical information.

Update your contact information as soon as it changes including any changes to your regularly used email address. Pinon will not use your standard email account for security reasons, but notifications are sent to your standard email address when a message has been sent to you and is waiting for you on your Patient Portal.

Withdrawal of this informed consent must be done by written online communications or in writing to Pinon Family Practice.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the Patient Portal and consent to the conditions outlined herein. In addition, I agree to the instructions outlined herein, as well as any other insructions my physician may impose to communicate with patients via online communications (consent of use of the Patient Portal). I have had a chance to ask any questions and received answers.

_____ *Initial*

Appointment Reminder Calls & Follow-up Communication

TEXT MESSAGE, EMAIL AND INFORMED CONSENT: In order to enhance patients' care and experience, Pinon Family Practice may send appointment reminder calls/text messages/e-mails for appointments scheduled 5 or more days in advance. We may also have important announcements to send, such as when it's time for flu shots or return appointment, bloodwork or vaccine notifications. We may also contact you after your visit in order to request feedback on your experience by phone call, SMS text message, e-mail, voicemail, or mobile application, some of which may be via automated means. By signing below, you understand and agree to be contacted in this manner with communications related to this visit, and any future visits.

If you are **not** interested in these services, please select the "**Opt out**" option at the bottom of this form. If in the future you would like to opt-out, you may do so by notifying us in writing Standard telephone minute and text messaging charges may apply when we contact you.

MOBILE SAFETY TIPS: While we work hard to protect your information, remember that electronic communication is never 100% secure. It's very unlikely, but information you send via text, email or mobile application, or that you leave on your mobile device, could be exposed to people other than your doctor. Here are a few safety tips to follow:

- Use a password on your mobile device to prevent strangers from seeing what is on your phone.
- **DO NOT** send sensitive health information to us and do not REPLY to messages sent. These will not be replied to and are immediately deleted. Please send a portal message or call us to discuss something private or sensitive.
- If you are worried about those close to you seeing your messages, you can delete them from your email or messaging app. This won't erase them completely, but will make it hard for others to see them.

(Please select one)

_____ I choose **to receive** calls/text messages (we will use the primary cell noted on the Patient Information form)

~OR~

_____ I choose **to opt-out** of receiving calls/text messages (**No reminder calls/text messages!)**

I agree that a photocopy or digital image of this agreement shall be as valid as the original.

**If under 18 years of age, you must have a parent or guardian sign below.

Print Patient Name: _____ **DOB:** _____

Signature of Patient, Guarantor or Agent: _____ **Date:** _____