DESCHUTES RIM
HEALTH CLINIC

Authorization to Leave a Message and/or communicate via Text, Email, Telehealth, or Voicemail Electronic Communications

Patient Name: _____ Birthdate: _____

Deschutes Rim Health Clinic (DRHC) understands that your privacy is important. We are required by law to maintain the privacy of Protected Health Information (PHI). There are limitations to ensuring confidentiality should you choose to communicate electronically by text, email, or voicemail.

- DRHC will not share text/emails outside of the agency without a Release of Information (ROI)
- For your protection, please limit electronic communications to brief messages and avoid providing detailed or sensitive information that may identify you. Do not use your social security number, last name, or date of birth
- Electronic communications cannot be guaranteed as secure as per HIPAA regulations
- Voicemails/answering machine messages consist of DRHC information, a call back number, and name to call back. Voicemails are also used to inform appointment times and dates. If you do not have voicemail which identifies you, we will be unable to leave any details.

Please INITIAL BELOW the level(s) of communication you are comfortable with:

I understand that the use of electronic communication means that my confidentiality cannot be guaranteed to HIPAA regulations. Knowing this, I give DRHC permission to communicate with me via:

_____ Text _____ Email _____ Voicemail

-OR-

_____ Other: I give DRHC **limited permission** to communicate with be **as described**: _____

_____

-OR-

_____ I DECLINE to give DRHC permission to communicate with me via any electronic communication means.

_____ I give DRHC permission to enroll me in telehealth appointments when available and for appropriate types of appointments

Signature: _____ Today's Date:_____

You have the right to revoke or amend this consent in writing at any time. This may require a new completed form.

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