PIGEON HEALTH COMMUNICATION CONSENT FORM

Pigeon Health is a doctor-to-patient communication tool utilized by this office to make it easier for patients to connect directly with their health care providers. The use of this service is completely optional. Please review the following policies, risks, and other information in order to decide whether you wish to utilize this communication tool.

Patient Name ____ Date of Birth _____/_____/_______
(Print full name)

This office uses text messaging to communicate with patients regarding scheduling and to allow communication with nurses and doctors. These messages could contain personal health information (PHI) and other confidential information. While any electronic communication can be intercepted, text messages (SMS) are not encrypted, and thus information is easier to obtain if these messages are intercepted.

To mitigate the risk of accidental release of PHI or interception of PHI by a third party, you have the option not to participate in the text message communication service. By choosing to participate in the text message communication service, you are acknowledging and assuming the increased risk of interception or release of PHI.

In order to comply with HIPAA (Health Insurance Portability and Accountability Act of 1996) regulations, we ask that our clients review and sign this Communication Consent Form.

Please **INITIAL** to confirm that you understand and agree to each of the following statements:

______ I understand that I am not required to use the Pigeon Health system.

______ I have received the disclosures highlighting the risks of using the Pigeon Health system and I am freely requesting to use it.

______ I understand that there are certain settings on my device (as described in the disclosures) that can help to protect the PHI on my device and that it is my responsibility to implement any changes to those settings.

______ I understand that, at any time, I can text the word "STOP" to the phone number provided to me to stop participating in the Pigeon Health system.

______ I understand that **I WILL NOT** use the Pigeon Health system in the case of a medical emergency. Instead**, I will dial 911**.

______ I understand that regular text rates apply and that I am responsible for any such rates and charges.

______ I understand that my messages may not be viewed right away. Specifically, this office only uses Pigeon between the hours of _______ and _______ Monday through Friday, excluding holidays.

______ I will notify my health care provider immediately in the event I change my telephone number.

By signing this waiver, I release and hold harmless Texas Health Care, its physicians, and its staff from any liability for the release of information pertaining to my medical care as specified above.

________________________________ _______________
Signature of patient or responsible person Date

________________________________ _______________
Relationship of Representative to Patient Date

________________________________ _______________
Signature of witness Date