Optometry Coding & Billing Alert

Sample Document: Authorization for E-Mail Correspondence

Susan Blair, MSJ, MBA, privacy officer at the University of Florida at Gainesville, shares how UF has set boundaries on how optometrists working at the university can communicate with patients over the Internet. First, for provider-to-patient e-mail messaging, the UF provider must give the patient cautionary information about e-mail security. Then the provider must obtain a signed patient
e-mail authorization:

Authorization for E-Mail Correspondence

Patient name _____

Date of birth_____

Medical record number_____

Verification of identity (photo ID, if patient is unknown)_____ Social Security no._____

*Complete the following only if the person completing the authorization is not the patient:

Name of representative_____

Relationship to patient_____

Legal authority _____

Verification of identity_____

Verification of authority_____

By signing this form, I authorize: (Person, class of persons, or organization)_____to communicate by electronic mail (e-mail) with me and with other healthcare providers as necessary for my/the patient's medical care and treatment.

I agree that e-mail messages may include protected health information about me/the patient, whenever necessary.

I understand that, by federal law, (Your Organization) may not use or disclose my health information, except as provided in (Your Organization) Notice of Privacy Practices, without my authorization. My signature on this Authorization indicates that I am giving permission for the uses and disclosures of the protected health information described above. I hereby release (Your Organization) and its employees from any and all liability that may arise from the release of information as I have directed.

I understand that I have the right to revoke this Authorization at any time. If I want to revoke this Authorization, I must do so in writing, and address it to the person or institution named above.

I understand that if I revoke this Authorization, it will not apply to any information already released as a result of this Authorization.

I understand that I may refuse to sign this Authorization. I also understand that the institutions or individuals named

above cannot deny or refuse to provide treatment, payment, or enrollment in a health plan or eligibility for benefits if I refuse to sign this Authorization.

I understand that, once information is disclosed pursuant to this Authorization, it is possible that it will no longer be protected by the federal medical privacy law and could be disclosed by the person or agency that receives it.

This Authorization expires automatically on (date or event)_____

I have read and understand the information in this authorization form.

Signature of patient or legal representative: _____

Please print name: _____

Date:_____

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