Dr. Luis Hines and Associates, PA
2828 SW 22nd Street, Suite 460, Coral Gables, Florida 33145
Telephone: (305) 642-5255 Fax: (305) 642-8850

Consent for Communication

I, _____ (Print Name), understand and consent to the communication protocols established by Luis Hines and Associates, PA, regarding my protected health information. I acknowledge the following:

1. **Method of Communication:** I consent to communication via email or text at the provided contact details. I understand the inherent risks associated with these methods, including lack of encryption and potential interception by unauthorized parties.

2. **Risks of Email and Text Communication:** I understand that emails, texts, and attachments may be vulnerable to interception, misaddressing, forwarding, and storage by unintended recipients. I acknowledge that such communications may not be secure and could be subject to inspection by employers or online services.

3. **Clinician's Responsibilities:** While clinicians will endeavor to maintain the security and confidentiality of email and text communications, they cannot guarantee absolute protection. Clinicians are not liable for breaches of confidentiality not caused by intentional misconduct.

4. **Usage Guidelines:** I understand that email and text communication should not be used for urgent or sensitive medical matters. I agree to keep communications concise and seek alternative means for complex or sensitive issues.

5. **Storage and Handling:** I acknowledge that emails, texts, and attachments may be included in my medical record. Clinicians will not forward identifiable communications without my written consent, except as required by law.

6. **Limitation of Liability:** Clinicians are not liable for breaches of confidentiality caused by me or any third party.

7. **Respect for Privacy:** All parties agree not to forward or share confidential communications with unauthorized individuals.

8. **Limitation of Liability:** Luis Hines and Associates, PA, will not be held responsible for privacy or security breaches occurring through authorized voicemail, email, or text communications.

Consent Preferences

☐ I do not consent to any voicemail, email, or texting communication.

☐ I consent to non-confidential communications (e.g., appointment scheduling) via:
- ☐ Email
- ☐ Text
- ☐ Voicemail

☐ I consent to all communications, including confidential medical information, via:

- ☐ Email

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☐ Text
☐ Voicemail

Contact Information:

E-mail Address: _____
Phone Number: _____
I understand that I have the right to revoke this authorization at any time without penalty.

Patient Information:

Name (Print): _____
Date: _____
Patient Signature: _____

Parent/Guardian Information (if applicable):

Name (Print): _____
Relationship to Patient: _____
Date: _____
Signature: _____
Clinician Signature: _____ Date: _____