5180 Buffalo Speedway
Houston, TX 77005
713. 490. 2225
713. 490. 2226 (fax)
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Protected Health Information Form

Our office will be happy to respond to your queries via email or telephone, but to do so via email and voicemail you must provide your consent, recognizing that email and voicemail are not secure forms of communication. There is some risk that any Protected Health Information (PHI) contained in email and/or voicemail messages may be disclosed to, or intercepted by unauthorized third parties. In an effort to protect your information we will use the minimum necessary amount of PHI to respond to your queries.

If you wish to conduct PHI discussions via email or using voicemail, please indicate your acceptance of this potential risk with your signature below. Alternatively, please call our office to arrange a phone conversation or office visit.

I authorize West University Wellness to communicate PHI via voicemail.	☐
I DO NOT authorize West University Wellness to communicate PHI via voicemail.	☐
I authorize West University Wellness to communicate PHI via email.	☐
I DO NOT authorize West University Wellness to communicate PHI via email.	☐

SIGNATURE

Patient Signature	Date
Patient Name (Print)	DOB

I hereby affirm that I am the legal parent or guardian of patient and have authority to make decision regarding medical treatments.

Parent/Guardian: Last Name, First Name, Middle Initial | Parent/Guardian Signature