Patient Authorization Form

Phamily is a text, mobile, and web based messaging platform that helps connect health care providers, patients and their loved ones. Your health care provider has chosen to use Phamily to get updates on your health, send you reminders, answer questions, and improve access to your health care provider.

Patient Name *(Print)*: _____

Patient Date of Birth: _____

Patient Mobile Phone Number: _____

By signing below:

1. I represent that I am eighteen (18) years of age or older and I acknowledge that I have read and agree to be bound by the Phamily End User Terms of Use as may be updated from time to time, (my.phamily.com/patient_tou.pdf).
2. I hereby authorize **Peninsula Nephrology Associates** ("Provider") and other medical professionals or staff members that the Provider has designated to access and use the Phamily services on its behalf, to communicate with me, and the Caregivers identified, if any, about my medical conditions and treatment using unencrypted text messages, if I have provided a mobile phone number, and/or unencrypted email, if I have provided an email address, including those that may be considered marketing messages (e.g. flu shot reminders, etc.).
   I acknowledge that text messages are inherently unsecure and may be able to be accessed by third parties.
3. I understand that *the Phamily service should only be used for routine and non-urgent matters. If you are experiencing a medical emergency or life-threatening symptom, please go to a hospital or contact 911 or your local emergency medical services agency.*

I understand and agree to participate in the Phamily service:

Signature: _____

Date: _____

Authorized Caregivers *(Optional)*:

I agree that the individual(s) listed below, if any, shall each be a "Caregiver" as defined in the Phamily End User Terms of Use.

Caregiver Name: _____

Relationship to Patient: _____

Caregiver Mobile Phone: _____

I hereby authorize the Provider and other medical professionals or staff members that the Provider has designated to access and use the Phamily Services on its behalf to communicate with any such Caregiver with respect to my medical conditions and treatment. I acknowledge that I may revoke this designation at any time by contacting the Provider. I also understand that in order to participate in Phamily on my behalf any such Caregiver must agree to the Phamily End User Terms of Use.