COMMUNICATION AUTHORIZATION FORM

Child Neurology of SLO
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Chronic care management is often needed in children with two or more chronic illnesses. 24/7 access to medical care is often required to maximize their level of functioning. Phone and electronic communication are often required. Signing this form gives Dr. Balke and staff consent to communicate with me by phone, email, electronic communication, and to coordinate care with other healthcare providers, pharmacists, therapists, or other agencies.

We want to make sure you know that email communications between us are not encrypted and therefore are not secure communications. If you elect to communicate with Child Neurology of SLO from your workplace computer, you also should be aware that your employer and its agents may have access to email communication between us. Email communication may become a part of your patient medical record and be accessible to my clinical support staff as needed for our operations.

Incoming email communications will be reviewed and responded to as soon as possible. If you have not heard from me with a response and are concerned we may not have received the message, please call the office during regular business hours. **Email communication should never be used in the case of an emergency or for urgent requests for information.**

By signing this form I am agreeing to allow Dr. Balke and staff to implement this chronic care management as needed and I authorize my insurance to be billed for the time this entails. I understand that I can revoke this authorization at any time verbally or in writing.

Signature:

Printed Name:

Patient's Name:

Date:

Email Address:
(Optional)

Patient's DOB: