Patient Permission for Electronic and Cell Phone Communication

I _____ DOB: _____ authorize _____ (the "Practice/Department") to communicate with me electronically or by cell phone, as set forth in this form, with respect to the following patients:

Patient Name: _____ Date of Birth: _____
Patient Name: _____ Date of Birth: _____
Patient Name: _____ Date of Birth: _____
Patient Name: _____ Date of Birth: _____

I have read, understand and agree to the terms of this form.

Regular Communications

The Practice/Department regularly communicates with its patients regarding appointment reminders, billing inquiries, prescription refills, making referrals, lab and other test results, and other general medical and business matters. With respect to these general communications, I give the Practice/Department permission to communicate with me via the following methods (please check all that apply and provide the appropriate number or address):

☐ Cell phone – by voice or text (_____ - _____ - _____)
☐ E-mail (_____ @_____)

Special Communications

Additionally, the Practice/Department may wish to make me aware of health care services or products that it, or its partners or affiliates, offers or provide me with educational health information, such as a newsletter. By checking the box below, I give the Practice/Department permission to send these communications via the e-mail address provided above.

☐ I authorize the Practice/Department to send e-mail communications as described above.

Conditions for Use of Electronic or Cell Phone Communications

I understand that:

1. If an automated dialing system may be used to make calls or send text messages to cell phone numbers, by providing my cell phone number above I am authorizing the Practice/Department to use such automated dialing system to call my cell phone.
2. The Practice/Department can't promise security and confidentiality when e-mailing or texting. The Practice/Department is not responsible if e-mails or texts are received or read by others as a result of transmission to the addresses or numbers above.
3. I can cancel this permission at any time. I must cancel in writing and provide it to the Practice/Department named above. It may take 30 days for the cancellation to become effective.
4. I do not have to sign this form. My refusal won't affect my ability to get treatment, payment for treatment or benefits. I understand that I will not be able to communicate by e-mail with my doctor's office if I do not sign this form.

If I communicate with the Practice/Department by e-mail, I understand that:

1. E-mail should **not** be used for:
   a. medical emergencies or issues that must be handled quickly.
   b. communicating information that is particularly sensitive. Examples may include: HIV, mental health, drug abuse, sexually transmitted diseases or pregnancy test results.
2. If I do not receive a response to an e-mail or I am directed to make an appointment, I am responsible for calling the Practice/Department to follow-up.
3. This permission does not obligate the Practice/Department to communicate with me by e-mail and the Practice/Department may cease e-mail communications or change the terms or e-mail communications at any time.

Patient's Signature	Date/Time	Witness Signature	Date/Time
Signature of Authorized Person	Date/Time	Relationship to Patient	
Healthcare Provider Signature	Date/Time		

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted _____ ☐ Interpreter Refused
(Name/Number of Person/Services Chosen/Used)