PATIENT COMMUNICATION PREFERENCES & HIPAA ACKNOWLEDGMENT FORM

PATIENT NAME: _____ DATE OF BIRTH: _____

PHONE NUMBER: _____ EMAIL: _____

Communication Preferences

Please select how you would like to receive communications from our office (check all that apply):

☐ Text Messages (SMS) ☐ Phone Calls

☐ Email ☐ Voicemail

(SMS Consent for Text Messaging and Email)

If I choose text messages and email, I acknowledge and agree that:

- Email and text messages may include limited protected health information (PHI), such as my name, appointment dates/times and office-related updates.
- Standard text messaging and email are not a secure method of communication and may be subject to interception or unauthorized access.
- This office will use reasonable safeguards but cannot guarantee the security or confidentiality of text messages and emails.
- Message and data rates may apply
- I may revoke my consent at any time by replying STOP to text messages or notifying the office in writing.

HIPAA Acknowledgment and Authorization

I understand that under HIPAA, I have rights regarding my protected health information. By signing below:

- I acknowledge that I have been informed of the risks associated with electronic communication.
- I authorize this office to communicate with me via the methods I have selected above.
- I understand that I am not required to consent to electronic communications as a condition of receiving treatment

Acknowledgement & Signature

I have read and understand this form. I agree to my selected communication preferences.

Patient Signature:_____ Date:_____

Office Use Only:

Staff Initials:_____ Date Entered into System:_____