



CONFIDENTIAL ELECTRONIC COMMUNICATIONS ACKNOWLEDGEMENT

Name of Patient: _____

Date of Request: _____ Date of Birth: _____

I authorize that the following communications from the practice be delivered to me by the provided electronic means. I understand that some forms of electronic communications may not be secure, creating a risk of improper disclosure to unauthorized individuals.

I am willing to accept that risk, and will not hold the practice responsible should such incident occur.

Communications (check all that apply)

_____ Email

_____ SMS Text Messaging

_____ Video communications (i.e. Skype)

_____ Other (list specifically): _____

E-mail Address: _____

Text Phone Number: _____

Skype Address: _____

Acknowledgement and Agreements: I understand and agree that the requested communication method is not secure, making my PHI at risk for receipt by unauthorized individuals. I accept the risk and will not retaliate against the practice in any way should this occur.

SIGNED: _____ Date: _____

Print Name: _____ Phone No.: _____

Address: _____

Personal Representative: _____

Request Received By/Date: _____