Generations Medical Center

Patient Agreement to Receive Electronic Communication

* You May Refuse to Sign This Acknowledgment*

Patient Name: _____ Date of Birth:_____

I agree that the practice may communicate with me electronically at the phone text # and/or email address below.

I am stating that the practice may use SMS Text to send messages to my cellular device and/or use Encrypted Email to send Email messages to the account listed below, which may contain Protected Health Information.

I am aware that it is my responsibility to secure these text and email inboxes on any device that may be checking these accounts, and that the practice will not be held responsible if my Patient Information is observed by anyone other than myself. I acknowledge that the practice will always send Email communication using HIPAA-compliant encryption. I further acknowledge that once the information is received into my text or Email inbox that the information integrity and security is my sole responsibility.

I am responsible for providing the practice any updates to my phone text # and/or email address, including changes and or termination.

I can withdraw my consent to electronic communications by contacting the practice in person or by phone.

SMS Cellular Phone Text Number: _____

Email Address (PLEASE PRINT CLEARLY): _____

Patient Signature: _____

Date: _____