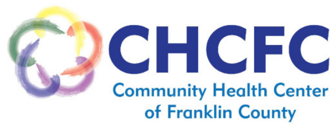

ELECTRONIC COMMUNICATIONS AUTHORIZATION

Please review and complete the following preferences for electronic communications, so that we may best serve and coordinate your health care needs with the use of the latest technology:

E-Mail Address: ______________________ @ __________________ . ________

☐ YES!	Please contact me by e-mail, including but not limited to: appointment reminders, medication refills, care coordination, other Health Center publications, and messaging to support access to my secure patient chart online. I understand regular e-mail is insecure in transit over the internet, and so all e-mail communications from the Health Center to me that contain protected health information (PHI) will be encrypted unless I specifically request otherwise.	☐ NO, I do not have e-mail access, or I do not wish to be contacted via e-mail at this time.

Text Message (SMS): (______) ______ - __________

☐ YES!	Please contact me by text message (SMS), including but not limited to: appointment reminders, medication refills, care coordination, other Health Center publications, and messaging to support access to my secure patient chart online. I understand the receipt of text messages may incur additional charges from my texting provider, and I am solely responsible for this expense. I understand text messages may be insecure in transit, and so messages from the Health Center to me will not contain protected health information (PHI), unless I specifically request otherwise.	☐ NO, I do not have text (SMS) access, or I do not wish to be contacted via text message at this time.

Health Information Exchange (HIE)

☐ YES!	Please utilize all available electronic communication technologies for the secure and efficient coordination of my care with my other health care providers and community-based organizations, including but not limited to the Massachusetts Health Information Highway (Mass HIway), Pioneer Valley Information Exchange (PVIX), electronic referrals (e-Referral), and electronic prescription history synchronization (RxHx).	☐ NO, I object to the use of secure electronic communications using HIE technologies at this time. I understand this preference limits my clinical team to the use of inefficient fax and paper records for coordination of my care with my other health care providers, including in the event of a medical emergency.

This authorization is effective as of the date indicated below. I understand I may modify these communication preferences at any time. Please allow 48 business hours for processing.

______________________	______________________
Patient Name (Print)	Signature of Patient, Parent or Guardian
______________________	______________________
Date	Relationship to Patient (if applicable)

OFFICE USE ONLY:

MRN: __________	RCVD ___ / ___ / ___	☐ ORIGINAL ☐ REVISED	☐ PM UPDATED ______