



# ELECTRONIC COMMUNICATIONS AUTHORIZATION

Please review the following practices that the health center uses to communicate with you electronically. Your signing this form and providing us with your email and/or phone number, constitutes acceptance of and your acknowledgement of these communication practices. If you would rather not have us communicate using phone or text, please be sure to check the **NO** box to the right of each box.

**E-Mail Address:** \_\_\_\_\_ @ \_\_\_\_\_ . \_\_\_\_\_

<p><b>WE WILL CONTACT YOU BY EMAIL</b>, 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.</p>	<input type="checkbox"/> NO, I do not wish to be contacted via e-mail at this time.
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**Text Message (SMS):** ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

<p><b>YOU MAY RECEIVE TEXT MESSAGES FROM US</b>, 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.</p>	<input type="checkbox"/> NO, I do not wish to be contacted via text message at this time.
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## Health Information Exchange (HIE)

<p><b>WE WILL UTILIZE ALL AVAILABLE TECHNOLOGIES</b> 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).</p>	<input type="checkbox"/> 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.
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*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 ___ / ___ / ___	<input type="checkbox"/> ORIGINAL <input type="checkbox"/> REVISED	<input type="checkbox"/> PM UPDATED _____
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