HIPAA - PATIENT CONSENT FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with **DE LA VEGA PEDIATRICS., "**Notice of Privacy Practices"., and I am giving my consent for the use and disclosure of Protect Health Information as required and / or permitted by law.

Patient Name: *(please print)* ____

Patient Signature *(or legal representative; proof may be requested)* ______________________________

Date: ____________________________

EMAIL/TEXT MESSAGE TO MOBILE PHONE CONSENT FORM

Purpose: This form is used to obtain your consent to communicate with you by email/mobile text messaging regarding your Protected Health Information. **DE LA VEGA PEDIATRICS., (DVP)** offers patients the opportunity to communicate by email/mobile text messaging. Transmitting patient information by email/mobile text messaging has a number of risks that patients should consider before granting consent to use email/mobile text messaging for these purposes. **DVP** will use reasonable means to protect the security and confidentiality of email/mobile text messaging information sent and received. However, **DVP** cannot guarantee the security and confidentiality of email/mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email/mobile text messaging between **DVP** and me and consent to the conditions outlined herein. Any questions I may have had were answered.

Patient Acknowledgment & Agreement

My Consented Email Address is:____

My Consented Mobile Number For Text Messaging is:________________________________

Patient Signature:______________________________ **Date:** ____________________

IN CASE OF EMERGENCY: *Please call 911 or proceed to the nearest emergency room.*

Do not use this way of communication for that purpose. *(5) Rev.01/22*