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|  | **The University of Oklahoma**  **Insert Department Information Here** |

**Request for Electronic Communication**

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| Last: |  | | | First: | |  | | Middle: |  |
| Date of Birth: | |  | Address: | | | | City: State: | | |
| Email Address: (Please Print Clearly) | | | | | Text Number | | | | |

I understand that I should not use electronic communication such as email or text message to contact my provider in the case of a need for emergency care.

I understand that refusal to sign this Consent will not affect my ability to obtain treatment from the above named provider.

I authorized the OU entity named above or its agent to contact me based on the information I have provided on this form. I understand communications may concern all matters associated with my treatment and payment for my treatment, such as appointment reminders, insurance and billing information, and contacts to collect of any unpaid balances. I understand the security or email and text messages cannot be guaranteed and that unauthorized individuals may be able to access the messages.

I understand that I may revoke this consent at anytime by providing the OU entity named above with a verification of my identity and completing the Request for Alternative Communication form. \*\*

\*\*This will not apply to communications that have been sent prior to the revocation date.

The information authorized for release via email communication also may include drug/alcohol abuse treatment information. This category of medical information is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit anyone receiving this information from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. As a result, by signing below I specifically authorize any information included in my health information to be released via electronic communication.

I understand the information sent via electronic communication may include information which may indicate the presence of a communicable disease or non-communicable disease.

I understand that this service of electronic communication is offered solely on the discretion of the OU entity named above and may be withdrawn at any time.

I understand this is not a request for release of my medical records.

**I understand and agree to the statements above and wish to have electronic communication sent to me by the OU entity named above.**

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| Signature of Patient, Parent or Legally Authorized Representative\* | Relationship to Patient | Date |