TOWN PEDIATRICS, PC
PATIENT/PARENT CONSENT FOR ELECTRONIC COMMUNICATIONS

Patient Name: _____

Date of Birth: _____

Parent/Legal Guardian Name: _____

Relationship to Patient: _____

Email Address: _____

Town Pediatrics, PC offers text messaging as a convenient way to communicate with patients and their parents or legal guardians regarding appointments, administrative matters, and certain healthcare-related information. We respect your privacy and are committed to protecting your personal health information in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and applicable state and federal laws.

1. Consent to Electronic Communications

- By signing this form, I authorize the practice to communicate with me by text message using the mobile telephone number I provide.
- Communications may include appointment reminders, confirmations and scheduling information.
- Requests to contact the office regarding test results or follow-up care.
- Prescription refill notifications and other care coordination messages.
- Billing, insurance, and administrative information.
- Other healthcare-related communications when appropriate.

2. Privacy and Security Risks

- I understand that standard SMS text messages may not be encrypted or transmitted through a secure healthcare communication system.
- Text messages may be viewed by other individuals who have access to my telephone, mobile account, or electronic devices.

- Text messages may be stored by telephone carriers, service providers, or on personal devices.
- Although the practice takes reasonable precautions to protect patient information, the confidentiality of standard text messaging cannot be guaranteed.
- I am responsible for notifying the practice promptly if my telephone number changes or my device is lost or stolen.

3. Limitations of Text Messaging

- Text messaging is not appropriate for emergencies or urgent medical concerns.
- Text messages may not be reviewed immediately and should not be relied upon for time-sensitive medical advice.
- In the event of a medical emergency, I should call 911 or seek immediate emergency medical care.
- The practice may require certain medical information or clinical concerns to be communicated through a secure patient portal, telephone call, or office visit.
- The practice reserves the right to determine which types of information may be communicated by text message.

4. Voluntary Participation and Withdrawal of Consent

- Participation in text messaging is voluntary.
- I may decline or withdraw my consent at any time by notifying the practice in writing or following the practice instructions for opting out.
- Declining text messaging will not affect my ability to receive medical care or treatment.

5. Parent Transmission of Photos and Medical Information

- I may voluntarily send photographs, videos, text messages, symptoms, or other medical information concerning my child to Town Pediatrics, PC.
- Electronic transmission of photographs or medical information carries privacy and security risks.
- Images or messages submitted may become part of my child's medical record.
- Submission of photographs or messages does not guarantee an immediate response.
- Electronic communications should never be used for urgent or emergency concerns.

6. Authorization and Acknowledgment

- I have read and understand the benefits and potential risks of electronic communications.
- I voluntarily authorize Town Pediatrics, PC to communicate with me electronically within the limitations described above.
- I understand that this consent does not authorize the practice to disclose my child's protected health information to individuals who are not otherwise legally authorized to receive it.

Communication Preference

☐ I consent to receiving text messages and electronic communications from Town Pediatrics, PC.

☐ I decline electronic communications and prefer communication through telephone calls or other approved methods.

Authorized Mobile Telephone Number: _____

I certify that I am the parent, legal guardian, or legally authorized representative of the patient identified on this form and that the contact information provided above is accurate and authorized for communications from Town Pediatrics, PC.

Parent/Legal Guardian Signature: _____

Relationship to Patient: _____

Date: _____