CONSENT FOR TEXT, EMAIL & VOICE MESSAGING

Community Volunteers in Medicine (CVIM) is offering a new text and email messaging support program to patients. Examples of these messages are reminders and health education programs. This is a form to get your consent. **Signing this form is voluntary**. It will not have an effect on the treatment you get from us.

Cost. There is no fee for being part of the Program. Standard text message and minute usage rates from your mobile or Internet service provider may apply.

Risks. Sending and receiving text, email and voice messages from us may impact the privacy and security of your Personal Health Information ("PHI"). Examples of PHI are: name, medical condition, or insurance coverage.

- Text, email and voice messages are not encrypted. Encryption makes sure your information stays safe. Information in text, email and voice messages may not be secure.
- If you share your phone, email, or your mobile phone is lost or stolen, someone other than us may be able to access your PHI. Messages can be read, used or shared by people other than us.

I, the Patient, understand and accept each of the following:

- **I authorize (**CVIM**) to send me text, email and voice messages.** This includes (but is not limited to) treatment- or care-related reminders and health education information.
- Text, email, and voice messages from (CVIM) may contain PHI. I will be responsible for information I share with (CVIM).
- This consent will be in effect as long as I receive treatment from(CVIM). I can ask (CVIM) for a more secure form of communication, like telephone or fax.
- I will let (CVIM) know if my mobile phone number changes or if I no longer want to be part of the Program. I can send an email (rfrost@cvim.org) or call (610-836-5990). I can also send a letter to ( ).
- I have a right to receive a copy of this consent form for my records.

I have read the above information and, by signing below, I confirm:

____ Yes! I want to participate in the Program. Mobile Phone: (_____) _____ – _____
Email: _____@_____ **Landline Phone:** (_____) _____ – _____

____ No. I do not want to participate in the program.

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Printed Name of Patient or Patient's Representative Representative's Relationship to Patient