

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 **VERITAS MEDICAL GROUP INC .**, “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. **VERITAS MEDICAL GROUP INC., (VMG)** 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. **VMG** will use reasonable means to protect the security and confidentiality of email/mobile text messaging information sent and received. However, **VMG** 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 **VMG** 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.