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| ou-logo | | | | **The University of Oklahoma** | | | | | |  | | | | | | | |
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| **Request and Consent for Electronic Communication**  **(Excluding Patient Portal and Secure Email)** | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| Last Name: | |  | | | | | First: |  | | | | Middle: | | |  | | |
| Other Names Used: | | | | |  | | Birthdate: | |  | | | | | | | | |
| Address: |  | | | | | | City: |  | | | State: | |  | | | Zip: |  |
| Home Phone: | | | ( ) | | | Alt. Phone: | | ( ) | | | Cell Phone: | | | ( ) | | | |
|  | | | | | | | | | | | | | | | | | |

I authorize OU to communicate with me via:

text: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

- or -

email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

It is my responsibility to notify OU at the above telephone or address if my contact information changes.

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 form will not affect my ability to obtain treatment from the above named OU entity.

I authorize the OU entity named above or its agent to contact me using 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 collection of any unpaid balances. I understand the security of email and text messages cannot be guaranteed and that unauthorized individuals may be able to access the messages.

I understand that I may revoke my consent at any time by providing the OU entity named above with a verification of my identity and completing the Request for Alternative Communication form. Revocation will not apply to communications that have been sent prior to the revocation date.

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

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

I understand that this service of electronic communication is offered solely at 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 Authorized Legal Representative\*** |  | **Relationship to Patient** |  | **Date** |

**\*May be requested to show proof of representative status**