Belmont
MEDICAL ASSOCIATES

**CONSENT TO USE OF ELECTRONIC COMMUNICATIONS**

| First name: | Last name: | | Date of Birth: |
|---|---|---|---|
| Address: | City: | State: | Zip: |

I consent to communicate with Belmont Medical Associates using the following means of electronic communication.

| | | |
|---|---|---|
| Text message | Yes No | Telephone number<br>( ) _____ -_____ |
| Video conferencing / Telehealth | Yes No | |
| Portal | Yes No | Email Address |

| Initials | |
|---|---|
| | I understand that this request to receive electronic communications will apply to all future appointment reminders/feedback/health information unless I request a change in writing. |
| | I understand that I have the right to withdraw my consent to receive/obtain text message communication from Belmont Medical Associates at any time. |
| | I agree to notify Belmont Medical Associates if my telephone number or email changes. |
| | I understand that I assume any costs incurred related to receipt of text messages. |

Patient Acknowledgement and Agreement:

I understand that electronic media and delivery methods such as e-mail and text messaging pose certain risks to the privacy and security of my protected health information. By my signature below, I agree to assume such risks personally and to hold Belmont Medical Associates and agents harmless in the event that my protected health information is breached or compromised because of my directing and authorizing Belmont Medical Associates and agents to transmit or deliver such information electronically. Any questions I had have been answered. I have reviewed and understand all of the risks, conditions, and instructions described in this consent form.

Patient (Please print): _____

Signature: _____ Date: _____