

New Light Medical Group Electronic Communication Consent Form

Patient Information:

- Patient Name: _____
- Date of Birth: _____

- Parent/Guardian Name: _____
- Relationship to Patient: _____

- Email Address (to be used for communication):

Consent for Electronic Communication via Email and Text Message:

I, _____ [Parent/Guardian Name], understand that New Light Medical Group offers the options of electronic communication, including both email and text messaging, as a convenience to its patients and their families. These forms of communication may be used to convey health information, appointment reminders, billing information, and other necessary communications related to the care of my child, _____ [Patient Name].

Acknowledgment and Understanding:

- **Privacy and Security:** I understand that while New Light Medical Group will employ reasonable measures to protect the privacy and security of email communications, the nature of email, particularly for inbound communications from patients, means it is not entirely secure. Consequently, there is a risk that the confidentiality of such communications could be compromised by third parties, including hackers or unauthorized individuals who gain access through lost or stolen devices.
- **Types of Communication:** I understand that not all medical information is suitable for email communication and that the pediatric office reserves the right to determine which types of information will be communicated electronically.
- **Responsibilities:** I agree to notify the pediatric office immediately if my email address changes. I also agree to take precautions to safeguard my email account and to promptly read messages from the pediatric office.
- **Consent Withdrawal/ Opt-Out Option:** I understand that I have the right to withdraw this consent at any time by notifying the pediatric office in writing.

Please note: New Light Medical Group is committed to maintaining the privacy and security of your personal health information. All outbound communications containing personal health information, including emails and texts, are conducted through HIPAA-compliant methods to ensure your data is protected in accordance with federal regulations. If you have any concerns or questions regarding our communication practices, please contact us.

Risks and Benefits:

- **Risks:** Include the risk of interception by third parties, the risk of miscommunication due to errors or omissions in the electronic communication, and the risk of viruses.
- **Benefits:** Include the convenience of receiving information quickly and efficiently, the ability to communicate effectively with the pediatric care team, and the enhanced coordination of care.

Patient Rights:

- I understand that my decision to communicate electronically does not affect my right to receive professional care.

Agreement:

By signing below, I acknowledge that I have read, understood, and agree to the terms of this Electronic Communication Consent Form. I consent to the use of email/text message as a method of communication between New Light Medical Group and myself regarding my child's medical care.

Parent/Guardian Signature: _____ Date: _____