University Pain Centers
University Pain Physicians

INFORMED CONSENT FOR ELECTRONIC COMMUNICATIONS

I hereby consent to receiving electronic communications from University Pain Centers, LLC., University Pain Physicians, LLC. and Anesthesia Management Partners, Inc. including, but not limited to, appointment information, medical results, protected health information, billing, and invoices. I understand that the information sent to me via email and/or via text message from persons at from University Pain Centers, LLC., University Pain Physicians, LLC. and Anesthesia Management Partners, Inc. **may NOT be sent securely and may be unencrypted**. I understand the risks associated with that including, but not limited to, that my protected health information may be read by an unintended third party. [This includes the possibility of cyber hacking.]

I have been notified of the risks. I understand said risks and I still prefer to receive protected health information via unsecure communications via email and text message. I understand that University Pain Centers, LLC., University Pain Physicians, LLC. and Anesthesia Management Partners, Inc. and its staff are not responsible for any unauthorized access of my protected health information communicated by way of unencrypted email and text and that I, as the patient, bear the risk by choosing to communicate in this manner. I understand that, at times, my doctor will be unable to respond to my electronic communications within a timely fashion and I know that if I am experiencing an emergency or have symptoms that are different or unusual, I should contact the office and/or go to the emergency room.

Patient name: _____

Patient signature: _____

Date: _____

Patient cell phone number: _____

Patient email address: _____