GEORGIA VASCULAR INSTITUTE

VASCULAR AND INTERVENTIONAL RADIOLOGY

CONFIDENTIAL ELECTRONIC COMMUNICATIONS ACKNOWLEDGEMENT

Name of Patient: _____

Date of Request: _____/_____/_____ Date of Birth: _____/_____/_____
MONTH DAY YEAR MONTH DAY YEAR

I authorize that the following communications from the practice to be delivered to me by the provided electronic means. I understand that some forms of electronic communications may not be secure, creating a risk of improper disclosure to unauthorized individuals.

I am willing to accept that risk, and will not hold the practice responsible should such incident occur.

☐ Email Email Address:_____

☐ SMS Text Messaging App Text Phone Number: (_____)_____-_____

☐ Video (i.e. Skype) Skype Address:_____

☐ Other (list specifically): _____

Acknowledgement and Agreements: I understand and agree that the requested communication method is not secure, making PHI at risk for receipt by unauthorized individuals. I accept the risk and will not retaliate against the practice in any way should this occur.

Signed:_____ Date:_____

Print Name:_____Phone No.: (_____)_____-_____

Street Address:_____

City: _____ State:_____Zip: _____

Personal Representative: _____

Request Received By: _____ Date: _____/_____/_____
MONTH DAY YEAR