The Cecil Specialty Clinic:
Hep C, Hep B, HIV, PrEP, and STIs

HIPAA AUTHORIZATION FOR USE/DISCLOSURE OF INFORMATION, CONSENT TO RECEIVE TEXT MESSAGES OR EMAILS

Patient Name:
(Last)_____(First)_____(M)_____

Age _____ DOB_____ SS# _____

Address:
Street_____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone_____

HIPAA Privacy & Security rules require your permission to use email or text messaging as a means of contact.

Please initial next to each if you allow us to use email or text for:

Test results _____ Appointment Reminders _____ Medical Conditions _____

To ensure that The Cecil Speciality Clinic is acting in accordance with your wishes, using your personal information with your authorization, and communicating with you in a manner with which you authorize, we ask you to sign this form to keep as a copy of your written permission on file. I specifically authorize text messaging or email communication. I understand I am not required to authorize communications and can opt for other means of communication.

_____ _____

Signature Date