Disclosures to Friends and/or Family Members
I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

Name 1: ____

Name 2: ____

Name 3: ____

Consent for Photographing or Other Recording for Security and/or Health Care Operations
_____ I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the hospital's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside of the practice without a specific written authorization from me or my legal representative unless otherwise required by law.

Consent to Receive Text Messages or Emails about Appointment Reminders:
Patients in our practice may be contacted via email or text messaging to remind you of an appointment.
_____ I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive appointment reminders. I understand that this request to receive text messages will apply to all future appointment reminders unless I request a change in writing.
The cell phone number that I authorize to receive text messages for appointment reminders is______________________________.
The email that I authorize to receive text messages for appointment reminders is______________________________.
The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Revocation

I hereby revoke my request for future communications via email and/or text.

__*I hereby revoke my request to receive any future appointment reminders via text messages.*

__ *I hereby revoke my request to receive any future appointment reminders via email.*

NOTE: This revocation only applies to communications from this practice.

Patient Name: ____

Patient/Patient Representative Signature: ________________________________

Date: ______________________ *Time:* ______________

300 StoneCrest Boulevard, Suite 110 · Smyrna, TN 37167 · Phone: (615)223-9233 · Fax: (615)768-7833 · TriStarMedGroup.com