Northwell Health

OUTPATIENT CONTACT CONSENT FORM

Email, Text Messages, and Voicemail

It is important for Northwell Health to be able to communicate with you about your healthcare. By providing an email address or phone number, you agree that Northwell Health, its contractors and their subcontractors may use those means of communication, including autodialed phone calls*, autodialed text messages, and voicemails, for purposes of communicating about your healthcare, including appointment related information, providing portal invitations, health reminders, identity authentication, prescription information, test results, and information about billing and payment for the medical services you receive. Message and data rates may apply to text messages, and not all carriers are covered. You can always text STOP to stop (a confirmation message will be sent) or HELP for help.

Messages sent through email or SMS text will be limited in the information they contain to protect your privacy. These text messages and emails are not encrypted in transit and may be accessed by others not affiliated with Northwell Health while in transit or upon receipt. To reduce the chance that your information is seen by the wrong recipient, we suggest you enable the highest security measures on your personal devices (passcodes, strong passwords, two step authentication, etc.).

Methods of communication:

If you DO NOT want Northwell to communicate with you via the email or phone number you provided, please initial below. **Please note:** If you opt out of communication below, you may still receive information necessary to access or prepare for in-person or virtual appointments (such as links to health visits), as well as specific communications you request.

_____ DO NOT email me

_____ DO NOT text me

_____ DO NOT leave a voice mail message for me

It is important for you to keep your contact information with Northwell Health up to date and review your email and phone numbers at each visit. **If you have previously opted out of e-mail, text messages and/or voicemails and express a change in your preferences on this form at this visit, you have opted back into all future e-mail, text and/or voicemail communications.**

*This includes autodialed phone calls to landlines and cell phones.

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My Care Contacts

☐ Check here if you do not wish for us to speak with anyone but you.

If you would like to authorize Northwell Health to communicate with other individuals about your healthcare, please indicate your communication preferences below. The care contacts below are not applicable in NYS Office of Mental Health (OMH) – licensed programs. I give Northwell Health consent to communicate with the following individual(s) about my healthcare (such as appointment details, prescription information, test results, billing and payment).

Name:_____

Relationship:_____

Phone Number: _____

Name:_____

Relationship:_____

Phone Number: _____

Name:_____

Relationship:_____

Phone Number: _____

Acknowledgement

By signing below, I understand that Northwell Health has my permission to contact me or my Care Contact(s) identified on this form in the manner described herein. I understand that I am responsible for notifying the office staff if there are changes to my designated communication preferences. If I am signing this document on behalf of another person, I acknowledge that I am consenting on behalf of the patient and I will indicate my relationship to the patient where specified below.

_____ _____

_____

Patient/Agent/Relative/Guardian* (Signature) ~~Date~~ ~~Time~~ Print Name Relationship if other than patient

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Telephonic Interpreter's ID #	Date	Time	
OR			
Signature: Interpreter	Date	Time	Print: Interpreter's Name and Relationship to Patient
Witness to signature (Signature)	Date	Time	Print Witness Name

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.