CIFC Health

Patient Communication Consent Form

At CIFC Health, we strive to provide you with excellent care and timely communication. By signing this form, you consent to receive messages from CIFC Health, including appointment reminders, scheduling updates, test results, and other healthcare-related information, through the methods below.

Contact Consent

By providing your contact information you give permission to be contacted in the ways you check below:

Cell: _____

☐ Text ☐ Non-confidential message ☐ Detailed message ☐ Do not leave message

Home: _____

☐ Text ☐ Non-confidential message ☐ Detailed message ☐ Do not leave message

Work: _____

☐ Text ☐ Non-confidential message ☐ Detailed message ☐ Do not leave message

Email Address: _____

By providing your email address, you will be granted access to the patient portal and consent to receive email communications.

☐ By checking this box I decline access to the patient portal and to receive email messages

Electronic Messaging

☐ By checking this box I acknowledge:

- Message frequency may vary
- Standard message/data rates may apply for SMS
- I may opt out of text messages at any time by replying **STOP**
- Carriers are not liable for delayed or undelivered messages
- Privacy Policy: For more information about how we protect your information, please review our privacy practices available on our website at https://www.cifc.org/home-page/page/website-disclaimer

Authorized Contacts

Authorized people with whom we may share your personal health information (PHI):

Name: _____ **Relationship:**_____

Phone: _____

Share Info: ☐ Emergency Contact Only ☐ OK to share all PHI ☐ OK to share Behavioral Health and Substance Use Disorder information

Name: _____ **Relationship:**_____

Phone: _____

Share Info: ☐ Emergency Contact Only ☐ OK to share all PHI ☐ OK to share Behavioral Health and Substance Use Disorder information

Name: _____ **Relationship:**_____

Phone: _____

Share Info: ☐ Emergency Contact Only ☐ OK to share all PHI ☐ OK to share Behavioral Health and Substance Use Disorder information

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Acknowledgment

I understand that:

- This consent does not expire. I can request changes to my communication preferences and contacts at any time
- CIFC Health will make reasonable efforts to honor my preferences
- Some communications may still be necessary for treatment or operations

Patient Name: _____ **Date:** _____ / _____ / _____

Signature of Patient or Parent/Legal Guardian: _____

Printed Name of Parent/Legal Guardian (if signed above): _____