CONSENT TO COMMUNICATE ELECTRONICALLY

What types of communication could be sent to me?

University of Kansas School of Medicine – Wichita Medical Practice Association "UKSM-W MPA" may send messages regarding your care, such as:

- Appointment reminders and scheduling updates
- Billing and payment notices
- Health-related information or education
- Feedback requests about your visit or services

How might I receive communications?

You may receive communications through one or more of the following:

- Email Notifications
- Text message (SMS)
- Phone or Voice over Internet Protocol (VoIP).

Some messages may be sent using automated dialing systems or include prerecorded/artificial voice.

Will the communications be secure?

Most emails will be encrypted. However, some emails or text messages containing limited personal information may not be encrypted and could pose a security risk. While the likelihood of interception is low, unencrypted messages may be accessed by unauthorized parties. By consenting to electronic communication, you acknowledge and accept this risk. UKSM-W MPA will take reasonable steps to protect your information but cannot guarantee complete security of unencrypted messages.

Are there any costs to me?

Standard text messaging or data rates may apply depending on your mobile plan. Please contact your wireless carrier for details.

What if I do not want to receive these communications?

You are not required to consent to receive electronic communications. You may opt out at any time by:

- Replying "STOP" to any text message
- Clicking "Unsubscribe" on any email
- Contacting your UKSM-W MPA clinic directly

Your preferences will remain in effect unless you update them or give a different type of consent for a specific clinic service or communication platform (such as a patient portal).

Consent Options (Select One):

☐ **I ACCEPT** – I consent to receive electronic communications from UKSM-W Medical Practice Association.

☐ **I DECLINE** – I do not wish to receive electronic communications at this time.

_____ _____

Patient Name ***(Print)*** **Date of Birth (MM/DD/YYYY)**

_____ _____

Patient Signature **Date**

If the patient lacks capacity or is a minor, signature of the parent, guardian, or authorized legal representative is required:

_____ _____

Representative Name ***(Print)*** **Relationship/Authority to Sign**

_____ _____

Representative Signature **Date**