Patient Communication Consent & Acknowledgment of Privacy Practices

Mid Cities Psychiatry respects your privacy and requires your consent to communicate with you via phone, voicemail, email, or SMS/text messaging for purposes including, but not limited to, appointment reminders, test results, Billing and administrative matters, and other clinical information.

If you are unavailable, we request your permission to leave certain types of information on your answering machine, voicemail, email, or SMS/text message. Please fill out the following and then indicate your preference by checking Yes □ / No □ of the boxes below.

Communication Type	Voice Call (Cell)	Voice Call (Home)	E-mail	SMS/Text
Appointment Date & Time Reminders	Yes □ / No □	Yes □ / No □	Yes □ / No □	Yes □ / No □
Appointment Follow-Ups	Yes □ / No □	Yes □ / No □	Yes □ / No □	Yes □ / No □
Test Results	Yes □ / No □	Yes □ / No □	Yes □ / No □	Yes □ / No □
Clinical Information	Yes □ / No □	Yes □ / No □	Yes □ / No □	Yes □ / No □
Billing Matters	Yes □ / No □	Yes □ / No □	Yes □ / No □	Yes □ / No □

By selecting "Yes," you authorize Mid Cities Psychiatry to contact you using the selected communication method(s), including leaving voicemail messages or sending email and SMS/text messages if you are unavailable. This authorization includes permission to communicate limited protected health information (PHI) as reasonably necessary for the purposes listed above.

Electronic Communication Risks (Email & SMS)
By selecting "Yes," you acknowledge and accept the following risks:

- Unauthorized access, interception, or disclosure
- Misdelivery due to incorrect contact information
- Storage or backup beyond deletion
- Potential access by third parties (e.g., employers or service providers)
- Use as legal evidence

Mid Cities Psychiatry cannot guarantee the security or confidentiality of electronic communications.

This consent may be revoked at any time by written notification, except where action has already been taken based on prior consent.

Patient Acknowledgment and Agreement:
By signing below, you acknowledge that you have read and understand this consent, including the risks of electronic communication, and authorize Mid Cities Psychiatry to contact you using the methods selected above.

Name of Patient	Date of Birth
Signature of Patient or Responsible Party (if minor Patient)	Date
Signature of Patient Representative (If Applicable)	Date