



## Notice of Privacy Practices & Communication Consent Form

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**I have received a copy of HealthTexas Medical Group of San Antonio's Notice of Privacy Practices.**

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

The patient or personal representative received a Notice of Privacy Practices but refused to sign above.  
After a good faith effort to obtain this acknowledgement I was unable to because:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Printed Name of Associate

\_\_\_\_\_  
Signature of Associate

\_\_\_\_\_  
Date

### Communication Consent Form

HealthTexas Medical Group has offered to communicate with you via-patient portal, secure messaging, and telephone voice mail and text<sup>1</sup>. This communication may include any of the following:

- Appointment information/directions/reminders
- Recommendation for follow-up
- General educational/treatment information
- Financial/billing information such as invoices and receipts
- Wellness Report
- Treatment summary for insurance purposes
- Test result data
- Specific treatment information
- Medication list

By acknowledging and signing this consent form, you are granting permission to HealthTexas Medical Group and any related affiliates or third-parties to contact you on the mobile and/or land line number(s) listed below. Please note that contacts may be made as a direct dial call or through the use of text messages, pre-recorded or artificial voice messages, and/or the use of an automated telephone dialing system or auto-dialer. In addition, depending on your mobile service plan, message and data rates may be assessed by your mobile provider.

You may withdraw consent or opt-out at any time by providing written notice to any HealthTexas Medical Group Clinic location or administration office.

Patient Signature \_\_\_\_\_ Patient Email Address \_\_\_\_\_

Patient (Print Name) \_\_\_\_\_ Patient Phone Number \_\_\_\_\_

Patient Cell Number \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

If patient under 18 years of age, Parent/Guardian Signature \_\_\_\_\_

Parent/Guardian (Print Name) \_\_\_\_\_

<sup>1</sup> Be advised that email, telephone voice mail and text communications are not secure and may be intercepted or disclosed to third parties.