Beckham Internal Medicine

Consent for Photographing or Other Recording for Security and/or Health Care Operations

____ (Patient/Representative initials) ***I consent*** to photographs, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

____ (Patient/Representative initials) ***I do not consent*** to photographs, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities).

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. I understand that once I have consented to receive communication via text or email, I still have the right to revoke that consent at any time.

If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the practice.

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

_____ (Patient/Representative initials) I **consent to receive text messages** from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is_____.

The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is_____.

OR

_____ (Patient/Representative initials) I decline to receive communication via text.
_____ (Patient/Representative initials) I decline to receive communication via email.

If you have previously consented to receive communication via text/email and wish to remove the consent, please complete the following form:

Revocation (I do not consent to the use of my cell or email any longer.)

___ *I hereby revoke my request for future communications via email and/or text.*
___ *I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text.*
___ *I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.*

Patient Name: _____
Patient/patient representative signature: _____
Date: _____

Prescription Order Pick-up. There may be times when you need a friend or family member to pick up a prescription order (script) from your provider's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

____ (Patient/Representative initials) I ***wish*** to designate the following individual to pick up a prescription order on my behalf:

Name: _____ Date: _____

Name: _____ Date: _____

____ (Patient/Representative Initials) I ***do not want*** to designate anyone to pick-up my prescription order.

Patient/parent/guardian/patient representative name (signature) _____ Date: _____

Patient/parent/guardian/patient representative name (printed) _____

Patient name (printed): _____ Date of birth: _____

Patient name: _____
Date of birth: _____