EMAIL AND TEXT COMMUNICATION AUTHORIZATION

Indiana University School of Optometry

Indiana University School of Optometry (IUSO) eye care clinics offer patients the convenience of email and/or text message (SMS) communication. Communications sent via email or text messaging are not secure and there is a risk the messages could be intercepted and read by someone other than the patient. Appointment reminders include: first name and date, time, and location of the appointment. A copy of all email and text communication can be used in court cases whether the information relates to your diagnosis and treatment or not.

IUSO will not send you electronic communication without your authorization on this form.

☐	I authorize IUSO to use email and text messages (SMS) to communicate with me regarding appointment reminders, order reminders, and patient portal set up.
☐	I do not want to receive email or text communications and revoke any previous authorization to do so. I understand I will receive communications by phone call only.

- I understand that I have the right to revoke this Authorization at any time by indicating so above. If I want to revoke this authorization, I must do so in writing and address it to the entity that I had previously authorized to disclose my information.
- I understand that if I revoke this Authorization, it will not apply to any information already released as a result of this authorization.
- I understand that this Authorization is voluntary and that I may refuse to sign it.
- I also understand that the IUSO cannot deny or refuse to provide treatment, payment, membership, or eligibility for benefits if I refuse to sign this Authorization.
- I understand only a minimum amount of information will be included and this authorization is for communication of appointments, reminders, and patient portal set-up. The appointment reminders will include: First name, date, time, and location of appointment.
- I understand that once information is disclosed pursuant to this Authorization, the information may no longer be protected under the HIPAA Privacy and Security Rules.

I have read and understand this Authorization and agree that email/text messages may include protected health information about me/the patient.

Patient/Representative's Signature	
Printed Name	
Today's Date	
Relationship to Patient	