St. Thomas East End Medical Center Corporation
4605 Tutu Park Mall, Suite 207
P.O. Box 503177
St. Thomas, VI 00805-3177

OFFICIAL USE
PT# ____________________
ID Verified: ________________
____
____
I:________RD: _____________

Tel: (340)775-3700
Fax: (340)777-7927

"Your Health is our First Priority"

CONSENT FOR COMMUNICATION

Patients/Clients frequently request that we communicate with them by phone, voicemail, email, or text. St. Thomas East End Medical Center Corporation (STEEMCC) respects your right to confidential communications about your protected health information (PHI) as well as your right to direct how those communications occur. Since email and texting can be inherently insecure as a method of communication, we will only communicate with you by email or text with your written consent at the email address or phone number you provide to us below. Please be aware that if you have an email account through your employer, your employer may have access to your email. When you consent to communicating with us by email or text you are consenting to email and texting communications that may **NOT** be encrypted. As well, voicemail or answering machine messages may be intercepted by others. Therefore, you are agreeing to accept the risk that your PHI may be intercepted by persons **NOT** authorized to receive such information when you consent to communicating with us through phone, voicemail, email, or text. STEEMCC will **NOT** be responsible for any privacy or security breaches that may occur through voicemail, email, or text communications that you have consented to. You may choose to limit the type of voicemail, email, or text communication you have with us if you wish to limit your risk of exposing your PHI to unauthorized persons. Please indicate below what types of correspondence you consent to receive by email, phone, or text. Initial:________________

PATIENT PORTAL INFORMATION

Once the registration form is completed and returned to the Health Information Management (HIM) Department, you will receive an e-mail with a link to the patient portal (within three business days). This will include your one-time login ID and one-time password information. Please make sure you check your bulk, junk, or spam e-mail because it may have filtered the e-mail there. Once you receive your one-time login ID and one-time password, please follow the prompts. Copy and paste your one-time user ID and password into the fields. You will be prompted to create a new username and password. You will need to read and accept the Terms and Conditions of the patient portal before it can be accessed. Whenever a new item is posted to your patient portal, such as results, reports, appointments etc., you will receive an e-mail notification. There will be a link at the bottom of the e-mail directing you to the portal login screen. No health information is relayed in any e-mail. All e-mail addresses will be kept confidential and will not be used for marketing or solicitation. Go to www.steemcc.org to access your portal or learn more about the patient portal.

Initial:________________

AUTHORIZATION

I authorize St. Thomas East End Medical Center Corporation (STEEMCC) to send text messages and/or email to communicate appointments, patient portal information and/or other communications that **DO NOT** reveal my PHI. I also authorize STEEMCC to create a patient portal Logon ID and password for the patient listed below. By accepting these terms, I agree that all individuals associated with my account may receive alerts referencing the account guarantor and/or dependents. I understand that the information will be emailed to me within 3-5 business days at the email provided below. Text message charges from my cell phone provider may apply. I understand that I may refuse to sign this consent and such refusal will not prohibit me from receiving treatment, payment for my treatment, enrollment in a health plan, or eligibility for benefits. I further understand that my refusal to sign this consent will not prevent me from receiving a copy of my medical records.

Patient Name:____Date of Birth:__________________________

Parent/Guardian (if applicable):____

Cell #:______________________________Email:____

Consent	**DO NOT** Consent	Preferred Method
☐ I **DO** consent to text messages	☐ I **DO NOT** consent to text messages	☐ Email
☐ I **DO** consent to phone calls	☐ I **DO NOT** consent to phone calls	☐ Phone call
☐ I **DO** consent to email	☐ I **DO NOT** consent to email	☐ Text messages
☐ I **DO** consent to patient portal	☐ I **DO NOT** consent to patient portal	☐ Website/ Portal
☐ I consent to **ALL** forms of communication	☐ I consent to **NO** forms of communication	☐ Video

Signature: ____ Date: ____________________________

Please print relationship to patient (if signed by a personal representative of patient): __________________