Authorization to Receive Medical Statements via Email or Text Message

Patient Name: _____

Date of Birth: _____

I hereby authorize **Inglewood Physical Therapy** to send medical statements and related billing information for the above named patient to me via the following electronic communication methods:

- **Email: _____**
- **Text Message (SMS): _____**

I understand and acknowledge the following:

- **Privacy Risks:** Email and text messaging may not be secure methods of communication. There is a risk that my protected health information (PHI) could be intercepted, accessed, or disclosed by unauthorized individuals.
- **Voluntary Consent:** I am not required to authorize electronic delivery of my medical statements. I may request paper statements at any time.
- **Revocation:** I may withdraw this authorization at any time by providing written notice to **Inglewood Physical Therapy**. Revocation will not affect any communications already sent before the date of withdrawal.
- **Accuracy:** I am responsible for providing accurate and up-to-date contact information and notifying the practice of any changes.

By signing below, I acknowledge that I have read and understood this authorization and agree to receive medical statements for the above named patient via the communication methods indicated above.

Signature: _____

Date: _____

Printed Name: _____

Relationship to Patient:_____