LA CLÍNICA DEL PUEBLO

PLACE LABEL HERE

Patient Communication and Disclosure

Please print all the information in the spaces provided. Be sure to complete all fields and sign below.

Disclosures to Others

I may give permission for my Protected Health Information to be disclosed for the purposes of communicating results, findings, and care decisions to family members and others. I will communicate the Name, Relationship, and contact information to the clinical team to ensure it is documented.

Consent for photographing or other recording for security and/or health care operations. I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes, and/or the practice's/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains ownership of 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 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 outside the facility without specific written authorization from me or my legal representative unless otherwise permitted or required by law.

Consent to email, cellular telephone, or text usage for appointment reminders and other healthcare communications. If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receive unsecured instructions and other healthcare communications at the email or text address I have provided at any text number forwarded or transferred from that number. These instructions may include but are not limited to, post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, family communications or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care. Note: You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Data Sharing

We value your privacy and are committed to protecting your personal information. We do not authorize mobile contact information to be shared with third parties or affiliates for marketing or promotional purposes.

Information may be shared with subcontractors and service providers who support our operations, such as customer service, technology, communications, and other services necessary to provide your healthcare and related services. These service providers are contractually obligated to safeguard your information and my use it only to perform services on our behalf.

All other categories of information sharing specifically exclude text messaging originator opt-in data and consent. Your SMS opt-in information, consent to receive text messages, and related mobile messaging data will not be shared with any third parties or affiliates for marketing or promotional purposes.

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La Clínica uses email, SMS, and other secure artificial intelligence (AI)-supported communication tools to communicate about appointment scheduling, reminders, patient engagement, care coordination, and responses to patient inquiries. AI-supported communications are managed in accordance with applicable privacy and security requirements.

AI-supported communication tools do not replace clinical judgment, direct communication with healthcare providers, or emergency medical services. Patients experiencing a medical emergency should call 911 or seek immediate medical attention.

☐ I do not wish to participate in SMS communications.

Revoking SMS Consent

To opt out of SMS communications at any time, text "STOP"

Communication via the Patient Portal

I acknowledge that the most secure means of communicating with La Clínica is the Patient Portal, available at www.lcdp.org/patient. I can ask a Patient Access Representative for assistance if I need to enroll or have questions about the Patient Portal. La Clínica will try to limit the information it includes in e-communications with me. I understand, however, that information about my medical care, including appointments, billing information, prescriptions, and test results, may be sent to me electronically. By signing below, I am choosing and consenting freely to electronic communications.

☐ I do not wish to participate in electronic communications via the Patient Portal.

By signing my name below, I acknowledge that I have read and fully understand the paragraphs above.

____   _____________________

Patient or Legally Authorized Individual's Signature   Date

Signed by (circle one): Patient / Parent / Legal Guardian / Caregiver