SOPHIE TRETTEVICK
INDIAN HEALTH CENTER
CLINICAL DIVISION

CONSENT FORM FOR TEXTING PATIENTS

COMPLETE ALL SECTIONS, DATE AND SIGN

I, _____ HEREBY VOLUNTARILY AUTHORIZE THE STAFF AT THE SOPHIE TRETTEVICK INDIAN HEALTH CENTER TO CONTACT ME AT CELL PHONE NUMBER _____ VIA TEXT MESSAGE FOR THE FOLLOWING PURPOSE:

- REMIND ME OF APPOINTMENT DATE AND TIME
- HAVE ME CALL THE CLINIC
- HAVE ME COME TO THE CLINIC
- PICK-UP REFERRAL OR OTHER DOCUMENTATION

I AGREE TO NOTIFY THE STAFF AT THE SOPHIE TRETTEVICK INDIAN HEALTH CENTER **WHEN MY PHONE NUMBER CHANGES**. I AGREE TO **SIGN A NEW CONSENT FORM** WITH A CURRENT PHONE NUMBER IN ORDER FOR STAFF TO CONTINUE TO NOTIFY ME WITH THIS METHOD.

THIS AUTHORIZATION WILL BE VALID FOR 1 YEAR FROM THE DATE OF SIGNATURE, AND BE REVOKED WHEN A NEW CONSENT FORM IS SIGNED.

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE *(Or witness if patient is unable to sign)*	DATE

FOR STIHC USE ONLY
NAME OF STIHC EMPLOYEE PROCESSING REQUEST
DATE REQUEST PROCESSED

NAME *(Last, First, MI)*	RECORD NUMBER
ADDRESS	DATE OF BIRTH

Approved 5/22/14