UPA Form #13

University Pediatric Associates, Inc.
PO Box 1026
Indianapolis IN 46206

Consent for appointment reminders via e-mail

Date:________________

Patient Name___________________________ MRN__________________________

Date of birth____

Parent or Legal Guardian

Signature____

Printed Name____

E-mail address____

I understand that by signing this form, I may receive appointment reminders via e-mail in addition to receiving them via phone calls. I further understand that the provider email system is not encrypted and that such email maybe intercepted, hacked, or read by others. I understand that I am responsible for access to my e-mail and computer and will not hold the provider's office responsible for any breach that may occur. Any changes to my email address must be delivered in writing, and not, by e-mail to the provider. E-mail communications will be limited and used only for receiving and responding to appointment reminders. Except for the applicable names and times and dates of appointments, no other personal information about the Patient shall be included in any e-mail.