MONROE CITY SCHOOL DISTRICT

and

Clarity Healthcare/Preferred Family Healthcare, Inc.

Authorization of Communication by

Wireless/Cellular Telephone

Patient Name:	Date of Birth:

_____I authorize Preferred Family Healthcare, dba Clarity Healthcare to send to and receive from me the information identified below by means of wireless or cellular telephone, whether in spoken or written forms of communication, such as text messaging, etc.

The following information may be communicated to me by wireless/cellular telephone:

*Refill reminders	*Appointment reminders	*Scheduling requests
*General care and treatment	*Referrals	*Other_____________________________________

I understand that use of wireless/cellular telephones may increase the risk of inadvertent or unauthorized disclosure of my protected health information to third parties. I understand that I am responsible for protecting or securing my own wireless/cellular telephone and any information I receive on such device.

Signature:	Date:

If you would like a copy of this authorization, please initial: _____Yes _____No

Witness Initials:_____