

Ascension Rx (Pharmacy)

Consent to Communicate Electronically

Please read this form completely and make sure that you understand. By signing this consent form, you are agreeing to allow Ascension Rx to communicate with you electronically about your pharmacy services. This may be by email, text message, or phone.

Ascension Rx as used in this consent refers to the retail pharmacies that are affiliates or subsidiaries of Ascension Health d/b/a Ascension Healthcare. Your choices with respect to this consent, including opt-in and opt-out, will only apply to your encounters and information associated with your retail pharmacy visits.

By signing this consent, you agree and understand that:

- Ascension Rx can communicate with you by electronic means including, but not limited to email, text message (SMS), and telephone, including VOIP (voice over internet provider), using pre-recorded messages, artificial voice messages, automatic telephone dialing devices, or other computer assisted technology, at the phone number and/or email address on file with Ascension Rx.
- Communications will include messages related to pharmacy services, including but not limited to: refill, expiration, and pickup reminders, copay notifications, mail order and shipment notifications, and set-up or unsubscribe confirmations.
- Standard text messaging rates may apply as provided in your wireless plan (contact your carrier for details).
- Texting (SMS) is not a secure method of transmission and the information contained in the text message is not encrypted. While the risk is low, the message could be intercepted or read by a third party and Ascension Rx cannot guarantee that text messages will remain secure and confidential.
- Communications may include your personal information, including but not limited to, your name and the name of your medication (prescription information).

Withdrawing Consent

I understand that I am not required to sign this form in order to obtain services from Ascension Rx. I understand that I change my preferences at any time, by either replying STOP to any text message or by contacting my Ascension Rx pharmacy directly for assistance.

Patient Name (Print)

Date of Birth (mm/dd/yyyy)

Signature

Date

If the patient lacks capacity or is a minor, signature of the parent, guardian, or personal representative is required.

Name (Printed)

Signature

Date

Relationship/authority to sign: _____