



AUTHORIZATION FOR RELEASE
for the
USE OF CELL PHONE/TEXT MESSAGING, EMAIL AND VOICE MAIL COMMUNICATIONS

Name: _____ DOB: _____

Address: _____
Street City State/Zip

Home Contact Number: _____

Cell Phone Number: _____

Email Address: _____

I, _____, hereby authorize/grant consent for the Kansas Medical Society-Professionals' Health Program, KMS-PHP to correspond with me via cell phone/text messaging, email and the use of voicemail for the general purpose of assisting me in compliance, case management, monitoring and advocacy. I understand that cell phone/text messaging, email and the use of voicemail communications are not secure forms of communication and that confidentiality of any cell phone/text messaging, email and voicemail information cannot be fully ensured. The KMS-PHP will maintain confidentiality and security measures to the greatest extent possible when utilizing cell phone/text messaging, email and voice mail communications.

Please initial here to indicate you understand the above: _____

I further understand:

1. This Authorization is effective for a period of 5 years from the date of its execution and/or the date of completion of my KMS-PHP contract/agreement and/or future addendums to said agreement.

2. I understand that I have the right to withdraw this authorization at any time via a request in writing to the KMS-PHP and further that this authorization shall expire, without my written revocation, five (5) years from the date provided below and/or the completion date of my KMS-PHP agreement or addendums to said agreement; except to the extent it is already being relied upon. I authorize a photocopy of this release to be used in lieu of an original signed document.

Print Name: _____

Date: _____

Signature: _____

Signature Witnessed By: _____

Date: _____