Text Message communication

You will no longer receive text reminders unless you have already completed and returned a copy of this consent form. Parents/Guardians can receive text message communications for children until they turn 12 years old, after which they will be switched off automatically. When the child turns 15 they will have the option to provide their own contact number for text communications. This is to protect the confidentiality of young patients.

Declaration

I consent to the practice contacting me by text message for the purpose of providing information about my care and information about the surgery.

Please tick to indicate that you understand and accept the following:

☐ Reminders by text are an additional service and they may not be sent on all occasions.

☐ Patients remain responsible for attending appointments or cancelling them.

☐ Patients can cancel the text message facility at any time by contacting the practice.

☐ It can take up to five working days for the consent to be administered on our system.

☐ Text messages are generated using a secure facility however it is important to understand that they are transmitted over a public network onto a personal telephone and as such may not be secure; on some occasions the text message may include patient details, for example their name, which could enable an individual patient to be identified.

☐ It remains the patients responsibility to inform Langport Surgery if their mobile is lost or stolen or if their number changes.

☐ I agree to the practice storing my personal data on the secure text message software.

Patient Name																														
DOB			/			/																								
Mobile Number																														

☐ I confirm this is my own personal mobile number for my own text communications.

Signature of patient……Date……

If you would like to receive text communications on behalf of another patient please confirm you meet at least one of the following criteria:

☐ The patient is a child in my care and is under 12 years of age

☐ I am a carer for the patient

☐ I have power of attorney for the patient

Name of patient	
DOB of patient	
Relationship	

Signature of representative……Date……

Signature of patient……Date……
(If appropriate)