Patient Consent

I authorize (Practice Name) to electronically send messages to communicate with me in regard to my scheduled or unscheduled appointments as provided below. I understand that it is my responsibility to notify the practice of any change in this manner of communication and that any disclosure made to the designated address or number, indicated by me, is subject to the redisclosure statement within this authorization.

Please use the following methods indicated below to message me regarding my appointments:

YES / NO Text: Cell / Mobile : ( ) _____

YES / NO Email: _____

YES / NO Phone Call: ( )_____

By my signature below I acknowledge that I have read and understand the guidelines to patient communication and information provided on this consent form.

_____

Patient / Authorized Signature

_____

Date