Patient Consent to Receive Mail, E-mail, and/or Telephone messages

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Please Print (Last Name) (First Name) (M.I.) (Date)

I agree that the practice may communicate with me electronically at the following addresses:

_____________________________ ____

Phone Number E-Mail Address *(please print)*

I consent to receive calls and text messages related to my protected healthcare and other services at the phone number(s) above. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

Do we have your permission to:

Send a recall appointment reminder to your home? Yes____ No____

Leave appointment, billing or dental information on your answering machine/voice mail/e-mail? Yes____ No____

I give permission to share appointment information with the person named below:

__________________________ _____________________ __________________________________

Name **Phone Number** **Email Address**

__________________________ _____________________ __________________________________

Name **Phone Number** **Email Address**

Acknowledgement of Receipt of Notice of Privacy Practices

I, _________________________ have received a copy of this office's Privacy Practices and I understand what I have received.

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Signature of patient/Parent or Legal Guardian Date

If signed by other than patient, please specify relationship to patient: _______________________________