



Consent to Communicate

Patient Name: _____

Please mark the ways that you consent to us communicating with you:

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Preferred Contact Method(s)	Best Time to Call*
<input type="checkbox"/> Call Work Phone	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
<input type="checkbox"/> Call Cell Phone	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
<input type="checkbox"/> Call Home Phone	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
<input type="checkbox"/> Send Email			<input type="checkbox"/>	-----
<input type="checkbox"/> Email Appointment Reminders				
<input type="checkbox"/> Email Medical Information				
<input type="checkbox"/> Email Office Specials				
<input type="checkbox"/> Send Regular Mail			<input type="checkbox"/>	-----
Mail to which Address: <input type="checkbox"/> Home <input type="checkbox"/> Other (please list):				
<input type="checkbox"/> Send Text Message - if ok, please list cell carrier (e.g., AT&T):			<input type="checkbox"/>	-----
<input type="checkbox"/> Text Appointment Reminders				
<input type="checkbox"/> Text Office Specials				

*Best Time to Call Examples: morning, afternoon, daytime, evening, emergency only, do not call, or do not leave a message

If it's ok to leave a message with another person, please list them:

Name	DOB	Relationship	OK to Release Results	Any Comments
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	

Signature: _____

Date: _____