PAVILION FAMILY PHYSICIANS

AUTHORIZATION FOR COMMUNICATION

Patient Information:

Name – Last, First, MI:		DOB:
Street Address:	APPT/ STE#:	
City:	State:	Zip:

You may choose to limit the type of voicemail or mail communications you have with us if you wish to limit your risk of exposing your protected health information to unauthorized persons.

Please indicate below what types of correspondence you consent to receive by:

Confidential Voicemail and (SMS) Text Messages:

☐ I consent to receiving a **Voicemail** regarding **appointments** to the following phone number:
Phone Number: _____
☐ I consent to receiving (SMS) **Text Messages** regarding **appointments** to the following phone number:
Mobile Number: _____
☐ I consent to **all voicemail communications**, about my medical condition and advice from my health care providers, including all results for the exception of any STI (Sexually Transmitted Infection) or any Mental Health Records to the following phone number: _____

Mail:

☐ I consent to **all mail communications** about my medical condition, advice from my health care providers, and results to be mailed to the authorized address listed above.

PLEASE NOTE: STI (Sexually Transmitted Infection) and Mental Health Records are exempt from this authorization.

If you choose not to consent to any of these methods of communications, please check box below:

☐ I DO NOT consent to any Voicemail, (SMS) Text Message, or Mail communications.

Signature of Patient/Legal Guardian: _____ **Date:** ___/___/___

Print Name: _____ **Relationship**: _____