Authorization to Fax/Email/Text

I recognize that communication done electronically does not have any guarantee of privacy, however due to convenience and timing, communications might be necessary by electronic means of fax, email, and text. I consent to communication specified below. Should I wish to withdraw the consent below I will notify the doctor/clinic in writing of the withdrawal of consent.

I, _____do hereby authorize Arlington Chiropractic Neurology Center to communicate with me via:

Fax: _____,

Email: _____,

Text: (mobile number) _____

By signing below, I agree to receive SMS messages for appointment reminders and clinical updates. Message frequency varies. Message and data rates may apply. I may opt-out at any time by replying STOP to any message.

No mobile information will be shared with third parties/affiliates for marketing/promotional purposes. All other categories exclude text messaging originator opt-in data and consent; this information will not be shared with any third parties.

Patient Signature: _____

Patient Name: _____

Date: _____