PATIENT E-MAIL AND TEXT MESSAGING REGISTRATION FORM

We now have the ability to provide our patients with certain types of information via E-mail or text messaging. If you would like to receive this feature in the future, please read the consent below and sign.

Consent to Email and/or Text Message for Appointment Reminders and Other Healthcare Communications:
Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

I consent to receiving appointment reminders and other healthcare communications/information at that email and/or text from Allergy Associates.

_____ **(*Patient initials*)** I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number.

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is (_____)_____-_____Carrier:_____

_____ **(Patient initials)** I consent to emails, to receive communications as stated above. The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is,
_____.

_____ **I DO NOT WISH TO RECEIVE E-MAILS OR TEXT MESSAGES.**

-I understand that this request to receive emails and/or text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing.

Print Patient Name:
_____DOB:_____
Patient/Parent or Guardian Signature:

_____Date:_____