**Patient Communication Authorization**

Patient's Name: _____ Date of Birth: _____

Lonna Larsh, MD and Amber Weiss, PA-C use e-mail extensively for communication. You authorize the use of email to contact you for the following matters:

Appointment confirmation and reminders ___yes ___ no

Discussion of confidential protected health information, including notification and discussion of test results ___yes ___no

Preferred email address: _____

Would you like to be enrolled in our patient portal, enabling online access to parts of your medical record? ___ yes ___ no

When contacting you by phone to discuss health concerns or test results,

It's okay to call:

_____ Home phone number: ( )_____ Leave a message: __ yes __no

_____ Mobile number: ( )_____ Leave a message: __ yes __no Text: __ yes __ no

_____ Work phone number: ( )_____ Leave a message: __yes __no

_____ Call only this number: ( ) _____ Leave a message: __yes __no

It's ok to leave a message with family members ___yes ___no

I give permission to the individual(s) listed below to receive protected health information:

_____

_____

This authorization can be revoked or modified by notifying us IN WRITING at any time.

Patient's Signature_____ Date_____