Patient Name: _____ Patient DOB: _____/_____/_____Date: _____/_____/_____

ELECTRONIC CONSENT CONTACT FORM

Patients may elect to receive communications via email, mobile text, and phone regarding personal medical information. By allowing the provider to communicate using this method, patients may receive appointment alerts as well as immunotherapy updates. Please be assured that all information will be kept confidential.

By my signature below, I agree that:

1) I would like to receive Short Message Service (SMS) messages and/or email pertaining to my allergy treatment, including, patient appointment or treatment reminders and other allergy related educational information to assist me in my allergy treatment;
2) I would like to receive a SMS message (as described above) through my communication service provider in order to deliver the SMS message to the mobile number listed below;
3) My communication services provider is acting as my agent in this capacity; and
4) I am providing a valid email and/or mobile phone number for these email and/or SMS messaging services.

There are no charges imposed by my provider for SMS message services, but I am responsible for any and all applicable charges or fees imposed by my communications service provider.

Patient Name: _____

Patient/Guardian Signature: _____

Patient E-Mail Address: _____

Patient Mobile Number: _____

Patient Mobile Carrier: _____

Note: *Consent for receipt of email or mobile text messages is not required as a condition of any allergy service or treatment. Consent to receive SMS and/or email notifications may be revoked at any time by following the "opt out" instructions included in the SMS communication copy that is sent to the email address listed. Please allow a reasonable period of time to process your withdrawal. The provider may terminate text and/or email messaging services from time to time, for any reason, and without notice.*