

**Patient Authorization for Appointment Reminders
Scheduling-Related Matters, Related Health Services
and/or Related Health Products**

It is our desire for our staff to use your name, address, e-mail address and /or telephone number for the purpose of contacting you to remind you about scheduled appointments or other appointment-related issues. We would also like to advise you about health-related meetings, workshop, and products.

The use of this information is intended to make your experience with our office more efficient, and productive. We want to enhance your access to quality health care. If you choose not to authorize this information use, your decision will have no effect on your care from us or your relationship with our staff.

Mailing Address

City	State	Zip
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E-Mail Address

Please indicate which number to use for:	Reminders	Messages	Don't Call
Home Telephone: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work Telephone: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cell Telephone: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E-Mail Address: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Would you like to be on our mailing list? Y N

Would you like to receive email newsletters? Y N

Your signature indicates your authorization of this activity.

Name (Printed)	Signature	Date
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You may revoke this authorization at any time. Please advise us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.