Consent to Communicate

Date:_____

Patient Name: _____ DOB:_____

The following people are permitted to receive information on appointments, testing, medications, and other health information for the above patient:

Name:	Relationship to Patient:	Restrictions: (No test results, no medications info, etc.)

The following people are permitted to bring the above patient in to be seen for appointments:

Name:	Relationship to Patient:	Restrictions: (Sick only, no physicals, no medication review/charges, etc.)

We are permitted to leave a voicemail message on the phone numbers in the above patient's file regarding appointment information, medication refills, testing, (results will NOT be left on voicemail) or other information regarding care? _____**Yes** _____**No**

Lapeer Pediatrics is asking for permission to send text message reminders for your upcoming appointments. **Cell Number**:_____

Can send general lab/test results via text:____**Y**____ **N**

Email Address (please write neatly):_____

Can send general lab/test results via Email: _____ **Y** _____**N**

_____

Signature (Patient/Legal Guardian) Relationship:

_____

Print Name: (Patient/ Legal Guardian