NEIL A . PATTERSON, M.D., P.A.

PATIENT CONTACT AUTHORIZATION

Completion of the following sections provides consent for representatives of Neil A. Patterson, MD, PA to perform certain actions. Please review carefully.

CONTACT

In regards to communicating pertinent information to me regarding any aspect of my health care I understand that I may be contacted by any means possible if there is an urgent need. For relaying general health and appointment information to me I prefer to be contacted by:

☐ **Patient Portal (email)** **email: _____**

☐ **Voice Mail**

☐ **Text**

If you choose Voice Mail or Text please indicate to which location you would like to receive these messages: **Home ☐** **Cell ☐** **Work ☐**

What time of day is best? **Morning ☐** **Afternoon ☐** **Evening ☐**

Please be advised that in some situations we are legally required to notify a patient via certified mail and the patient will be billed the cost of certification.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Print Name of Patient Print Name of Legal Guardian