<u>Patient Agreement for Communications</u>

I understand that as part of my health care ENT of Georgia will need to contact me from time to time in order to remind me of an appointment, providing the results of a test, giving instructions, or to provide other information.

I authorize ENT of Georgia to contact me in the following ways (check those which you authorize):

☐ Home phone	☐ Voice mail OK
☐ Work phone	☐ Voice mail OK
☐ Cell phone	☐ Voice mail OK
☐ Fax	☐ Text OK
☐ E-Mail	E-Mail Address:___________________________

ENT of Georgia, LLC does use a secure server for e-mail communication as required by law, however ENT of Georgia, LLC <u>does not endorse</u> the use of direct e-mail for communication with patients.

I understand that ENT of Georgia will use the minimum necessary information needed when communicating with me indirectly. I understand that I may revoke or modify this agreement at any time. Any revocation or change will not apply to past communications.

____ ______________

Patient name / signature Date

I further authorize ENT of Georgia to discuss matters related to my condition/care with the following:

___________________________________ _________________________

Name: (Please Print) Relationship:

___________________________________ _________________________

Name: (Please Print) Relationship:

I understand that ENT of Georgia will use the minimum necessary information needed when communicating with me indirectly. I understand that I may revoke or modify this agreement at any time. Any revocation or change will not apply to past communications.

____ ______________

Patient name / signature Date