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PATIENT COMMUNICATION CONSENT FORM

Patient First Name: ___________________________ Last Name: _____________________________

D.O.B: ______________ Primary Care Physician: ___________________

I agree to allow **Piedmont Pediatrics, LLC** to contact me in the following methods regarding my private health information, evaluation, and treatment. I authorize **Piedmont Pediatrics, LLC** to leave messages for me when I am unavailable.

	Method	**Number/Address**	**Messages (Yes or No)**
___	Home Phone	(____) _____ - _____	☐ Yes ☐ No
___	Cell Phone	(____) _____ - _____	☐ Yes ☐ No
___	Alternate Phone	(____) _____ - _____	☐ Yes ☐ No
___	Text Messages	(____) _____ - _____	☐ Yes ☐ No
___	Email	_________________@_____________	☐ Yes ☐ No
___	Patient Portal *(must provide email address for portal access)*	_________________@_____________	

I authorize Piedmont Pediatrics, LLC, and medical staff to discuss my healthcare information (which may include history, diagnosis, labs, test results, treatment and other health information) with the contacts listed below. I understand that by leaving spaces blank I am indicating my choice to be a "No Information" and I do not want any information released to anyone else.

Name	**Relationship to Patient**	**Contact Info**

By my signature below I acknowledge that I have read and understand the information provided on this consent form. I understand the risk associated with the different methods of communications, especially e-mail and texting, and consent to the conditions, restrictions and patient responsibilities as well as any other instruction **that Piedmont Pediatrics, LLC** may impose.

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Patient/Parent Name **Date**