FLORIDA AUDIOLOGY ASSOCIATES

COMMUNICATION CONSENT FORM

I (DO / DO NOT) give my consent for the practice to send text messages to my mobile phone for the purpose of providing health information and appointment reminders. I will ensure that I keep the practice informed of my up to date mobile number at all times, or if the number is no longer in use. I acknowledge the message and data rates may apply.
Should I not be able to keep an appointment I will call the office to cancel within 24 hours.

Signature: _____ Date: _____

I (DO / DO NOT) give my consent for the practice to leave voice messages on the phone numbers provided on my intake form for the purpose of health information and appointment reminders. I will ensure that I keep the practice informed of changes to my home and mobile number(s) at all times, or if the number(s) provided are no longer in use.

Signature: _____ Date: _____

I (DO / DO NOT) give my consent for the practice to send e-mail messages for the purpose of health information and appointment reminders. I will ensure that I keep the practice informed of my up to date e-mail contacts at all times, or if the e-mail address is no longer in use.
Should I not be able to keep an appointment I will call the office to cancel.

Signature: _____ Date: _____

I (DO / DO NOT) give my consent for the practice to share health information with my primary care physician. As a standard practice of care, Florida Audiology Associates recommends the release of information to primary care physicians. The sharing of information across your healthcare providers helps with continuity of care by keeping patient health records stored and easily accessible in one location.

Signature: _____ Date: _____

I (DO / DO NOT) give my consent for the practice to share health information and appointment reminders with outside persons including listed family members and other health practitioners.

Allowed parties for sharing of information:

Name:_____ Name:_____
Relation:_____ Relation:_____
Phone:_____ Phone:_____
Fax:_____ Fax:_____
E-mail:_____ E-mail:_____

Signature: _____ Date: _____

All patients reserve the right to change the status of any or all of the above consents. If you wish to change the status of these consents, please notify the office.

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