Consent to Email or Text

Consent to Email, text or telephone for appointment reminders and other healthcare communications: Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and provide general health reminders/information.

If at any time, I provide an email or text address or telephone number at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the practice (Eyes of Texas Vision Care).

_____(Patient initials). **I consent to receive text messages and emails from the practice.** I consent to receive texting at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing. (See revocation section below).

- The cell phone number that I authorize to receive text messages for appointment reminders, feedback and general health reminders/information is **_____**. **The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).**
- The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is_____.

My preferred mode of communication is: circle one or more: Telephone (cell) email text postcard

REVOCATION

I hereby revoke my request for future communications via email and/or text.

_____ (patient initials) I hereby revoke my request to receive any future appointment reminders, feedback and general healthy via text messages.

_____ (patient initials) I hereby revoke my request to receive any future appointment reminders, feedback and general health via email.

NOTE: This revocation only applies to communication from Eyes of Texas Vision Care.

Patient Name: _____

Patient/Patient Representative Signature: _____

Date: _____ Time:_____