The Piazza Center
FOR PLASTIC SURGERY & ADVANCED SKIN CARE

Consent to Communicate

Patient Name: _____ DOB: _____

Please mark the ways that you consent to us communicating with you

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Best Time to Call Please circle
☐ Call Work Phone	☐Yes ☐No	☐Yes ☐No	Any Morning Afternoon Evening
☐ Call Cell Phone	☐Yes ☐No	☐Yes ☐No	Any Morning Afternoon Evening
☐ Call Home Phone	☐Yes ☐No	☐Yes ☐No	Any Morning Afternoon Evening
☐ Send Email			
☒ Email Appointment Reminders are sent automatically			
☐ Email Medical Info			
Specials, discounts & upcoming events will be emailed to you unless you select ☐ No			
☐ Send Regular Mail			
Mail to which Address: ☐ Home ☐ Other (please list):			
☐ Send Text			
☐ Text Appt Reminders			
Specials, discounts & upcoming events will be emailed to you unless you select ☐ No			

Please indicate person(s) authorized for messages and/or records below.

Name	DOB	Relationship	OK to Release Results	Any Comments
			☐Yes ☐No	
			☐Yes ☐No	
			☐Yes ☐No	

Signature: _____ Date: _____

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