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|  | **Roberta L. Gartside M.D.***1800 Town Center Drive, Suite 412**Reston, VA 20190**Phone (703) 742-8004**Fax (703 ) 742-3749* |
|  |
|  Consent to Communicate |
|  |
| Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  |
| Please mark the ways that you give consent for us to communicate with you: |
|  |
| **Method** | **Use Patient ID** | **Ok to Leave Voicemail** | **Ok to Leave Message with Another Person** | **Preferred Contact Method(s)** | **Best Time to Call\*** |
| [ ]  Call Work Phone | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ]  |  |
| [ ]  Call Cell Phone | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ]  |  |
| [ ]  Call Home Phone | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ]  |  |
| [ ]  Email\*:  | - | - | - | [ ]  | - |
|  | Email to use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\*Please be aware that general email communication over the internet is **not** encrypted and may not be secure[ ]  Email Appt Reminders |
|  | [ ]  Email Medical Info |
|  | [ ]  Email Marketing/Specials Information |
| [ ]  Send Regular Mail | [ ] Yes [ ] No | - | - | [ ]  | - |
|  | Mail to which Address: [ ]  Home [ ]  Other (please list):  |
| [ ]  Send Texts | - | - | - | [ ]  | - |
|  | *\*Best time to call examples: AM, PM, ANY, or DO NOT CALL* |
|  |
| If you wish to give consent to allow our office staff to communicate about your medical health, insurance, billing matters, or appointments to anyone else, please fill out their information below: |
| **Name** | **DOB** | **Relationship** | **OK to Release Results** | **Any Comments** |
|  |  |  | [ ] Yes [ ] No |  |
|  |  |  | [ ] Yes [ ] No |  |
|  |  |  |  |  |

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_