

## Patient Agreement for Communication

I understand that as a part of my health care ENT of Georgia will need to contact me from time to time in order to remind me of an appointment, providing the results of a test, giving instructions, or to provide other information.

I authorize ENT of Georgia to contact me in the following ways (check those which you authorize and provide telephone number):

Home phone  
 Work Phone  
 Cell Phone

Voice mail OK:   
Voice mail OK:   
Voice mail OK:

ENT of Georgia, LLC does not use a secure server for e-mail communication. Because a secure server is required by law for e-mail communication with patients, ENT of Georgia, LLC does not support the use of e-mail for communication with patients.

I understand that ENT of Georgia will use the minimum necessary information needed when communicating with me indirectly. I understand that I may revoke or modify this agreement at any time. Any revocation or change will not apply to past communications.

\_\_\_\_\_  
Patient name/Signature

\_\_\_\_\_  
Date