

AzureWave Medical Services, LLC

Communication Preferences & Consent

Patient Name: _____
Date of Birth: _____
Primary Phone: _____
Email Address: _____

AzureWave Medical Services, LLC may communicate with you regarding appointments, test results, billing matters, care coordination, and general health information.

Please indicate your preferred methods of communication (check all that apply):

- Phone Call (may leave voicemail)
- Phone Call (do NOT leave voicemail)
- Text Message (SMS)
- Secure Patient Portal Message
- Email (non-secure)
- Email (secure, if available)

Text & Email Consent:

By selecting text or email communication, I understand that standard text messaging and non-secure email may not be encrypted and could carry some privacy risk.

I accept this risk and authorize AzureWave Medical Services, LLC to communicate with me using the methods selected above.

Voicemail Consent:

- I authorize detailed voicemail messages to be left regarding my medical care.
- Leave minimal message only (name and callback number).
- Do not leave voicemail messages.

Authorized Contacts:

I authorize the following individual(s) to receive information regarding my medical care and billing (name & relationship):

Name: _____ Relationship: _____
Phone: _____

Name: _____ Relationship: _____
Phone: _____

I understand that I may change my communication preferences at any time by notifying the practice in writing.

Patient Signature: _____

Date: _____