PATIENT COMMUNICATION CONSENT FORM (Page – 2/2)

Please complete this form in PART 1, PART 2 and your signature in PART 3.

PART 1

I agree to allow ID Doctor to contact me in the following methods regarding my private health information, evaluation and treatment. By ticking 'Yes' in the message box, I also authorize ID Doctor to leave voice or text messages for me when I am unavailable.

Method	Number / Address	Messages (Yes / No)
Home Phone	______________________	☐ Yes ☐ No
Mobile Phone	______________________	☐ Yes ☐ No
Email *	__________@__________	

* **Patient Portal** : If you agree to allow us to register your email, you can access our Patient Portal using your email address as a log-in name. You can log-in our Patient Portal through our website: www.iddoctor.ie

PART 2

I authorize ID Doctor and medical staff to discuss my healthcare information (which may include history, diagnosis, labs, test results, treatment and other health information) with the contacts listed below. I understand that by leaving spaces blank I am indicating my choice to be a "No Information" and I do not want any information released to anyone else.

NAME	RELATIONSHIP TO PATIENT	CONTACT INFO

EMERGENCY CONTACT ONLY -
NAME:______________________________ Phone: ____________________

PART 3

By my signature below I acknowledge that I understand the risk associated with the different methods of communication, especially e-mail and texting, and consent to the conditions, restrictions and patient responsibilities outlined within the Clinic Policies as well as any other instruction that the Clinic may impose. (Our Clinic Policies are also available to view on website www.iddoctor.ie)

____
Patient Name printed / DOB / Date

____
Patient/Authorized signature Relationship to patient