**CONSENT FORM**

**PATIENT NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I hereby authorize Women’s Health Associates of Western Mass. Inc., and their representatives to release or disclose any and all information pertaining to my health care, results, procedures, billing and/or accounting information to:

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_

Myself only □

**Consent to email or text usage for appointment reminders and/or billing information and payments due.**

You may be contacted via email and/or text messaging to be reminded of appointments and/or billing information. Email may be used for newsletters.

\_\_\_\_ (initials) I consent to receive t­­­­­ext messages from the practice at my cell phone and any number forwarded or transferred to that number, or emails, to receive communication as stated above. I understand that this request to receive emails and text messages may apply to all future appointment reminders and/or billing information unless I request a change in writing

The cell phone number that I authorize for the above use is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The email address that I authorize for the above use is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan. (Contact your carrier for pricing plans and details.)*

**I further authorize the physicians, Certified Nurse Midwives and their representatives to contact me in one or more of the following manners in order to leave a message to return a call to the physician’s office. (Please check as many as apply) Messages may involve returning calls for test results, appointment reminders, etc. when you are not available.**

□ Home Phone □ Cell Phone □ Work Phone □ Email

Patient or Patient Representatives Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_