*I acknowledge that I have been provided access to the patient portal for the office of Yolanda T. Grady, M.D., Inc. I consent to receiving Email messages for my appointment reminders and other healthcare communications. I understand that when I join the patient portal I will be contacted (via email) to remind me of* ***all*** *future upcoming appointments.* ***Unless I request a change in writing (see revocation section below), this will be the main method of communication with me. I understand that I will not be receiving phone calls to remind me of upcoming appointments. By joining the patient portal, I understand that it is my responsibility to read all e-mail communications from Yolanda T. Grady, M.D., Inc. and to change my e-mail address if it changes. I will incur a missed appointment fee if I don’t cancel my appointment within four (4) hours of my appointment time. Portal related medical care will be billed to insurance.***

*I consent to receiving* ***all*** *appointment reminders and any other healthcare communications at the email address provided below. \_\_\_\_\_\_ (Patient initials)*

*The email that I authorize to receive appointment reminders, general health reminders and information is:*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

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*Patient Signature Date*

***Revocation***

*I hereby revoke my request to receive any future appointment reminders, and other healthcare communications via E-mail.*

*NOTE: This revocation only applies to communications from Yolanda T. Grady, M.D., Inc.*

*Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Patient/Patient Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*