*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 sign up for 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 receive 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. We request that you keep daily portal communications to a minimum. I also understand that I will incur a missed appointment fee if I do not cancel my appointment within four (4) hours of my appointment time.*

***\*\*Email communication will be the Primary Method of Communication\*\****

*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, communication and information is:*

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

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*Patient Signature Date*

***OR***

***I DO NOT wish to receive communications via E- Mail.***

***\*\*PHONE CALLS will be the primary method of communication\*\****

***Revocation: (NO PATIENT PORTAL ACCESS)***

*I hereby revoke my request to receive any future appointment reminders, and all 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*