Gomathi Pediatrics PLLC
67 North Main Street, 2nd Floor
New City, New York 10956
Tel: 845-634-8911
Fax: 845-634-9002

Date:_____

PATIENT E-MAIL AND TEXTING CONSENT FORM

_____

Patient's Name

_____

Patient's Date of Birth

I, hereby consent and state my preference to have my physician, Dr. Gomathi Adhiyaman, and other staff at Gomathi Pediatrics PLLC communicate with me by email or standard SMS messaging regarding various aspects of my medical care, which may include, but shall not be limited to, test results, prescriptions, appointments, and billing.

I understand that email and standard SMS messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS messaging regarding my medical care might be intercepted and read by a third party.

I understand that carrier message & data rates may apply.

Name: _____Relationship:_____

Signature: _____

Date: _____