Goldman Dermatology, PLLC
150 Broadway, Suite 1110
New York, NY 10038

CONSENT for COMMUNICATION via E-MAIL/TEXT MESSAGE

PATIENT NAME:

EMAIL ADDRESS:

MOBILE NUMBER:

I hereby consent to have Goldman Dermatology, pllc, communicate with me or members of his staff where appropriate, or other health care professionals, via e-mail/text message regarding my medical care and treatment. I understand that e-mail/text message is not a confidential method of communication. I further understand that there is a risk that e-mail/text message communications between my physician and me or members of our physician's office staff or between my physicians and other physicians and health care professionals regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. I understand that in an urgent or emergent situation, I should call my provider or 911 or go the Emergency Room and not rely on e-mail/text message.

_____ _____

Patient or Responsible Party Date