Dr. Pam Wilson
Healing Bodies. Changing Lives.

Dr. Pam Wilson
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AUTHORIZATION FOR DETAILED PHONE MESSAGES

Patient name _____ **Date of Birth**_____

I UNDERSTAND THAT:

- It is my responsibility to keep my phone number (cell and landline) up-to-date with Dr. Pam Wilson's office.
- This authorization is voluntary and I have the right to refuse it.
- Treatment is not conditional on whether I sign this authorization or not.

By signing this form, I am allowing Dr. Pam Wilson's office to leave detailed messages on my cell/landline phone including:

- Allowing detailed phone messages to be left on the following phone numbers:
- Cell: _____ and/or Home: _____
- Notifying me of appointment confirmations, reminders or missed appointments.
- Informing me that testing results are back (actual results will NOT be conveyed over the phone).
- Informing me that supplements I have ordered have arrived in the office.
- Dr. Pam Wilson's office will never send any sensitive personal health information through text message.
- If I sign this authorization, I may revoke (cancel or opt out) of it later, at any time by informing Dr. Pam Wilson's office.

Signature(s):

Patient signature _____ **Date**_____

Sign below if you are a personal representative of the patient:

Representative signature _____ **Date** _____

Print name: _____ **Relationship to patient** _____