ADOBE
ENT & ALLERGY

# Communication Consent Form

By signing below, I give Adobe ENT & Allergy permission to communicate with me via email, text, cell phone number, home phone number given on the new patient form. I understand that the purpose of any such communication will be for appointment reminders, educational information, access to our patient portal, and for news related to our practice and or your provider that may affect you.

| Patient Name | Patient Signature | Date |
| --- | --- | --- |