



1900 E. Desert Inn Road, Las Vegas, NV 89169

contact@desertinnmedicalclinic.com

(702) 425-6125

(702) 208-2202



CONSENT for COMMUNICATION via E-MAIL and TELEPHONE (calls, voicemails, text messages)

I, (patient/guardian) _____, hereby consent to have my physician, _____, and his staff to communicate with me via email and telephone (calls, voicemails, text messages) regarding all aspects of my medical care/treatment (appointments, prescriptions, test results, billing, etc). Regarding email communication, I understand that it is not a confidential method of communication; it may be intercepted by third parties or transmitted to unintended parties. I understand that in an urgent or emergency situation, I should call my provider or go to Emergency Room and not rely on e-mail. I acknowledge that I have read and fully understand this consent form, and that I have the right to revoke this consent at any given time.

Patient/Guardian Name: _____

Patient/Guardian Email: _____

Patient/Guardian Phone Number: _____

Patient/Guardian Signature: _____

Date signed: / /