Vascular Care
OF TEXAS, PLLC

I agree to allow Vascular Care of Texas to contact me in the following methods regarding my private health information, evaluation and treatment. I authorize Vascular Care of Texas to leave message for me when I am unavailable.

	Method	Number/Address	Messages
____	Home Phone	(_____)_____	_____ yes _____no
____	Cell Phone	(_____)_____	_____ yes _____no
____	Work Phone	(_____)_____	_____ yes _____no
____	Alternate Phone	(_____)_____	_____ yes _____no
____	Text Message	(_____)_____	
____	Email	_____@_____	_____ yes _____no
____	Patient Portal	_____	_____ yes _____no

I authorize Vascular Care of Texas and medical staff to discuss my healthcare information (which may include history, diagnosis, labs, test results, treatment and other health information) with the contacts listed below. I understand that by leaving space blank I am indicating my choice to be "No Information" and I do not want any information released to anyone else. Please list all physicians that you would like medical information sent to, along with their contact information.

NAME **RELATIONSHIP TO PATIENT/PHYSICIAN** **CONTACT INFO**

_____
_____
_____
_____
_____

EMERGENCY CONTACT ONLY

NAME: _____ PHONE: _____

By signing below I acknowledge that I have read and understood the information provided on the consent form. I understand the risk associated with the different methods of communication, especially e-mailed and texting, and consent to the conditions, restrictions and patient responsibilities as well as any other instructions that Vascular Care of Texas may impose.

Print Patient Name _____ Date _____

Patient/Authorized Signature _____Relationship to patient _____