☐ Hoag Medical Group ☐ Hoag Urgent Care ☐ Hoag Physician Partners ☐ Hoag Concierge Medicine ☐ Hoag Specialty Clinic ☐ Hoag at Home

AUTHORIZATION TO SHARE PATIENT INFORMATION

Name: ____
LAST FIRST MIDDLE

Date of Birth: ______________________________

Phone Messages

Is there a phone number where the Hoag entity selected above and affiliates can call and leave **detailed** messages regarding your care, appointment/health screening reminders and other health care messages?

☐ Yes ☐ No If yes, please provide phone number: ______________________________

Text Messages

Do you wish to receive appointment/health screening reminders and other health care messages via text?

☐ Yes ☐ No

If yes, please provide preferred phone number to receive text messages: ______________________________

E-Mail

Do you wish to receive appointment/health screening reminder and other health care messages via e-mail?

☐ Yes ☐ No

If yes, please provide preferred e-mail address: ______________________________

Additional Contact

Is there someone else who the Hoag entity selected above and affiliates can leave **detailed** messages with and share your patient information?

☐ Yes ☐ No If yes, please provide:

Name: ______________________________ Relationship to Patient: ____________________

Phone Number: ______________________________

I hereby consent to receiving messages as indicated above from the Hoag entity selected above and affiliates. These parties may use the provided information to contact me by e-mail, live agent, voice mail, text message or pre-recorded message, including by using an auto-dialer or other computer assisted technology, or by any other electronic communication for purposes that include appointment and follow-up health care reminders, pre-registration, surveys, prescription information, health-related products or services that may be of interest, my account(s), assignment of benefits, and financial responsibility. I understand that depending on my phone plan, I could be charged for these calls or text messages. I also understand that providing this contact information and consent are not conditions to receiving health care services. With respect to text messages, I understand that I can opt-out at any time by replying "STOP" to the text message from my mobile device.

The Authorization to Share Patient Information remains in effect until a request to withdraw from this form is submitted in writing by the patient.

Patient/Legal Representative Signature: ______________________ Date: __________ Time: ______AM/PM
If signed by other than patient, indicate relationship: ______________________________
Print Name – Legal Representative: ______________________________