

**Patient Agreement for Communication**

**I understand that as a patient at Abramson Facial Plastic Surgery I may be contacted from time to time to confirm appointments, to be give special offers, etc.**

**I authorized Abramson Facial Plastic Surgery to contact me in the following ways:**

**(Please check those you authorize and provide the telephone number)**

- Home Phone** \_\_\_\_\_
- Work Phone** \_\_\_\_\_
- Cell Phone** \_\_\_\_\_
- Email** \_\_\_\_\_
- Fax** \_\_\_\_\_

- Voicemail OK**
- Voicemail OK**
- Voicemail OK**

**I understand that Abramson Facial Plastic Surgery will use the minimum necessary information needed when communicating with me indirectly. I understand that I may revoke or modify this agreement at any time. Any revocation or change will not apply to past communications.**

\_\_\_\_\_  
**Patient Name / Signature**

\_\_\_\_\_  
**Date**