Authorization to Contact

I authorize Main Street Clinic to contact me at the phone number listed _____for the purposes below including but not limited to:

- Appointment reminders
- Test results
- Billing notifications
- Request for feedback about your experience
- Care instructions.

I understand that:

- These messages may be delivered by voice call or text message (SMS/MMMS)
- Automated systems or pre-recorded messages may be used to deliver these communications.
- Test messages may not be encrypted and could be read by someone other than me.
- I may revoke this authorization at any time by notifying the practice in writing.

By signing this authorization, I certify that I am the owner of this cellular device and its user contract

Signature_____Date _____

Authorization for Release of Health Information

I hereby authorize Main Street Clinic to release any medical or incidental information to my referring provider or any other provider who have been or may become involved with my care. I also authorize the release of information that may be necessary in the processing of any

insurance claims.I hereby authorize Main Street Clinic and its employees permission to discuss, send and/or receive my personal health information to/with the following individual(s):

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Signature _____Date _____