Lombardi Institute of Dermatology, PLLC
Milan M. Lombardi MD
611 W Bay St. Suite 1E
Tampa, FL 33606
813-642-3164

Patient Communication Preference

I, ________________________________, hereby consent and state my preference to have my physician, Milan M. Lombardi MD, and other staff at Lombardi Institute of Dermatology, PLLC communicate with me by email or standard SMS messaging regarding various aspects of my medical care, which may include, but shall not be limited to, test results, prescriptions, appointments, and billing.

I understand that email and standard SMS messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS messaging regarding my medical care might be intercepted and read by a third party.

I agree to the above: **YES** or **NO** (circle one)

I prefer: **[ ] Text** **[ ] Email**

Mobile #:______________________________ Email:_____________________________

May we leave voice mail messages regarding your care or results? **YES** or **NO** (circle one)

I authorize Lombardi Institute of Dermatology, PLLC to provide me with information through an email, text message or mail service about products or services, including cosmetic products or services, that may be of interest to me: **YES** or **NO** (circle one)

Name:____ **Date:**_____________

Signature:______________________________________