Communication Consent

Ki Hassler D.O., F.A.C.C.
1215 Jacaranda Blvd
Venice, FL 34292
Phone: 941-451-8282
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Appointment Reminders

I agree to receive automated appointment reminders by

☐ Text Message ☐ Email ☐ Voice

Emergency Contact

First Name_____ Last Name_____

Relationship to patient _____

Home Phone_____ Work Phone_____

Mobile Phone_____ Preferred Phone: H W M

Health and Financial Communication

I authorize Ki Hassler D.O. LLC 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 spaces blank I am indicating my choice to be a "No Information" and I do not want any information released to anyone else.

NAME	RELATIONSHIP	PHONE NUMBER	DISCUSS FINANCIAL	DISCUSS HEALTH

Patient name printed _____

Printed name (if other than patient) _____

Relationship to patient_____

Patient/authorized signature_____ Date_____