**North Ridge Medical Practice**

**Over 13 Year Old and under 16 Communication Consent Form**

We would very much like to be able to send text and email message reminders for appointments and other information relating to our services. If this is service you would like to receive please complete this form.

Please enter below the mobile phone number and email address you would like us to use when contacting you directly. If you wish to provide your parent/guardian contact details, then by signing this form you are giving us permission to send any communications to them rather than directly to you.

**EXPLICIT CONSENT**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patient Name | Date of Birth. | Mobile Phone No | | Email address |
|  |  |  | |  |
| Parent/Guardian Name | | Mobile Phone No | Email address | |
|  | |  |  | |

**The Practice responsibility**

Patient confidentiality is really important to us. The practice will only send messages directly relevant to the management of your healthcare and any relevant information regarding North Ridge Medical Practice.

**My responsibility**

I understand that it is my responsibility to keep my contact details updated and that the practice will continue to use the details I have provided until I advise that it has changed. I also understand that I can withdraw my consent at any time by simply notifying the practice in writing.

|  |  |  |  |
| --- | --- | --- | --- |
| Patient Signature |  | Date of Signature |  |

**Written: September 2018**

**Review Date: September 2019**