Anne Arundel DERMATOLOGY and Affiliates

Patient Name: _____

Patient DOB: _____

COMMUNICATION REVOCATION REQUEST FORM

I hereby revoke my request for future communications via email and/or text as indicated below:

(Please select "Yes" option to stop receiving communications from the source(s) listed below should they apply, or select "No" to continue to receive communications from the source(s) listed below.)

I hereby revoke my request to receive any future appointment reminders, feedback, marketing and general health via *TEXT*. Yes ☐ / No ☐

I hereby revoke my request to receive any future appointment reminders, feedback, marketing and general health via *EMAIL*. Yes ☐ / No ☐

NOTE: This revocation only applies to communications from this Practice.

Patient Name Printed:_____

Patient/Patient Representative Signature:_____

Date:_____ Time:_____