



COASTAL PERINATAL CENTER



V. Sachar, MD, FACOG, CHCQM

Maternal Fetal Medicine, Perinatal Diagnostic Center

I, _____ hereby consent to have my physician/physician office Coastal Perinatal Center/Dr. V Sachar, communicate with me or members of his staff, where appropriate or other physicians, nurse practitioners and pharmacists via text message regarding my ultrasound report at the time of my appointments. I understand that text messages are not a confidential method of communication. I further understand that there is a risk that text messages communications between my physician and me or members of my physician's office staff, or between my physician and other physicians, nurse practitioners and pharmacists regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. I understand that in an urgent or emergent situation I should call my primary provider or go to the Emergency Room/Labor & Delivery and not rely on text messages.

Signature: _____ Date: _____

Email Address: _____

Cell Ph # (for text): _____