

Email Consent Form

By signing this form I agree to allow communication between myself and the staff at Dr. Michael Coppe and Dr. Carolyn Coppe Peacock regarding appointment reminders, patient referrals, and patient education. I also understand that I may also communicate with the Provider via telephone or during a scheduled appointment and that email is not a substitute for the care that may be provided during an office visit. Appointments should be made to discuss any new issues as well as any sensitive medical information.

Please note that emails should never be used for urgent problems, or sensitive medical information. In these cases you should call the office directly at (781) 861-6120.

Patient Name (printed)

Parent/Guardian Signature

Date