MACOUPIN

Family Practice Centers, LLP

Dear Patient:

In our quest to keep up with the changes and advances in technology, we would like the opportunity to communicate with our patients electronically.

We are requesting your e-mail address so that in the future we may be able to communicate with you electronically. Your e-mail address will not be shared with any unauthorized vendors. E-mail addresses will be part of your patient demographic record and will be shared with any specialists that Macoupin Family Practice Centers refers you to. If you do not wish for your e-mail address to be shared with specialists, please write "declined" in the e-mail address field on this form.

Patient Name_____Date of Birth_____

E-Mail Address:_____

Thank for letting us continue to serve your healthcare needs,

Macoupin Family Practice Centers, LLP

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