



445 Grant Ave, Suite 200 • San Francisco, CA 94108 • www.JadeHCMG.com

AUTHORIZATION FOR E-MAIL COMMUNICATION

As your affiliate medical group, Jade Health Care Medical Group and its affiliated health plans would like to communicate with you by e-mail about various items and services. By signing this authorization form, you will provide authorization for us to contact you via e-mail.

By signing this form, you will authorize Jade Health Care Medical Group and its affiliated health plans to communicate with you by e-mail about various topics and services. We will use the e-mail address that you provide below.

If you decide to revoke your authorization, it will not affect any previous e-mail communication that we had already sent to you. Please contact Jade's Provider Relations Dept. via email at info@Jadehcmg.com to opt out of all e-mail communications.

X

Signature of Provider

Provider Email Address

Provider Name

Date