FREEHOLD EAR NOSE & THROAT ASSOCIATES, P.A.
Otolaryngology | Face To Face: Plastic & Cosmetic Surgery

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AUTHORIZATION FOR E-MAIL COMMUNICATION

Patient Name: _____

Patient E-Mail Address: _____

As your physician, I understand that individually identifiable information about you and your health is private, and I am committed to protecting the confidentially of that information. I would like to communicate with you by e-mail about items and services that I think would supplement or enhance your treatment. Before instituting such e-mail communication, I wish to obtain written authorization to ensure that you agree to my sending such e-mail communication. By signing his form, you will provide authorization for me to contact you via e-mail. Pleases read the information below carefully before deciding whether to sign the form.

USE AND DISCLOSURE COVERED BY THIS AUTHORIZATION

By signing this form you will authorize me to communicate with you by e-mail about the items and services that I think would supplement or enhance your treatment. In order to send the e-mail confirmation, I will use the e-mail address that you provided above.

If you decide to revoke the authorization, that revocation will not affect any e-mail communication I had already sent to you in reliance on your authorization. Please contact the office to opt out of the e-mail communication.

SIGNATURE

I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read this form and wish to authorize my physician to communicate with me by e-mail, as described above.

_____ Date: _____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority