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E-Mail Authorization

I am signing this document to indicate that I authorize Dr. Erik Gustke to send me invoices and other confidential information by e-mail.

I understand that this means that the confidential information included in such e-mails is subject to the typical threats of confidentiality that exist with e-mail services and on the Internet. By using e-mail as a means to communicate confidential clinical information to Dr. Gustke, or his representative, via- statement, question, or request, I am implicitly authorizing Dr. Gustke, or his representative, to communicate confidential information in return and that the confidential information included in such e-mails is subject to the typical threats of confidentiality that exist with e-mail services and the Internet.

I am aware that Dr. Gustke's confidential voice mail- 919-903-9470, confidential fax- 919-903-9475 or the US Mail are always available as a means of confidential communication without the risks associated with the Internet. All questions, appointment scheduling, comments, medication refill requests, or other concerns may be initiated through the phone number -919-903-9470, or should be communicated directly.

_____ _____/_____/_____

Signature of Patient (and Parent if patient is a minor) **Date**

Notice of Privacy Practices Acknowledgement of Receipt

The Notice of Privacy Practices provides information about how protected health information about you may be used and disclosed.

In addition to the copy that has been provided for you, you may request additional copies from this office.

I acknowledge that I have received the Dr. Gustke's Office Policies, E-mail Authorization and Notice of Privacy Practices and am now responsible for knowing its contents.

_____ _____/_____/_____

Signature of Patient (and Parent if patient is a minor) **Date**

_____ _____

Print Name **Relationship**