E-MAIL AUTHORIZATION

___ E-Mail _____

____Please also mail a copy of my correspondence to my address on file.

By checking this box, I opt to receive my health care correspondence via email. I understand that Specialists in Internal Medicine/Executive Health Care takes as many reasonable steps as possible to protect confidentiality during the transmission of electronic information. I acknowledge and take responsibility for the small risk of unintended breaches of privacy, confidentiality, or security relating to email correspondence.

Signature:_____ **Date:** _____

FLASH DRIVE

_____ I am requesting my medical record be downloaded onto a Flash Drive*

*By checking this box, I opt to receive a copy of my executive physical on a flash drive, which is **not passcode protected** to ensure access in a medical emergency. I acknowledge and take responsibility for any risk of unintended breaches of privacy, confidentiality, or security relating to the flash drive.*

Signature:_____ **Date:** _____

Please send my Flash Drive to:

Printed Name: _____

Street: _____

City: _____ State ____ Zip _____

*Cost of the flash drive is $75.00, unless covered under your "program benefits"

Office Use Only: Date Flash Drive mailed _____