Patient Name:_____ Date: _____

Electronic Authorization

By providing my email address, I authorize Comprehensive Internal Medicine to contact me electronically to notify me of my upcoming appointments (both one week and one day before the actual date). I also consent to receive my lab results electronically through "Patient Fusion." I understand that I will receive an email immediately after my visit which directs me to the Patient Fusion Portal, to create a username and password, and also input the PIN number given to me upon check-out. This will allow me to connect directly to Comprehensive Internal Medicine to receive not only my laboratory data, but also view any diagnoses, immunization history, medications, allergy list, and any scheduled upcoming appointments.

_____

E-mail Address

_____

Patient Signature

Electronic Authorization Denial

I am requesting to continue receiving my laboratory data through the mail, as I do not have an email address in which I can receive my data electronically.

I also understand that any appointment confirmations will be completed via phone.

_____

Patient Signature