

**Beeson Aesthetic Surgery Institute
INTERNET COMMUNICATIONS RELEASE**

Name _____ Email: _____ Chart: _____

[PLEASE PRINT]

I, _____, authorize William H. Beeson, M.D., and Beeson Aesthetic Surgery Institute (BASI) and its agents to utilize the above noted Internet email address to provide contact with me regarding my medical care, education, and treatment opportunities. I wish for this authorization to remain in effect until I withdraw such authorization in writing.

I realize that the confidentiality of email or communications over the Internet cannot be insured, and I accept this. When communicating information that I feel is "sensitive" and I want to remain confidential, I will use the telephone or fax instead of sending over the Internet. I realize that Dr. Beeson and Beeson Aesthetic Surgery Institute will make every effort to check email on a regular basis. However, I accept that there may be times of delay in responding to my email communications. If issues are time-sensitive, I note that I will call to insure that communications have been received. If there is a delay in response to my email, I realize that I should contact the office directly by telephone to insure communication.

I acknowledge that Internet email is a convenient way for me to communicate and that Dr. Beeson wishes to provide this beneficial service to me. However, I also realize and accept that there are limitations. I acknowledge that information can be relayed efficiently via email, but that Dr. Beeson cannot "treat me" over the Internet. I also realize that the Internet should not be used for emergency, confidential, or sensitive communications with Dr. Beeson, Beeson Aesthetic Surgery Institute, or the BASI staff.

PATIENT SIGNATURE

DATE

PATIENT'S NAME (PLEASE PRINT)