

# RHEUMATOLOGY ASSOCIATES OF HOUSTON

## Email Authorization

I, \_\_\_\_\_, authorize Rheumatology Associates of Houston to email me with the results of my labs, diagnostic test and or any correspondence related to Rheumatology Associates of Houston.

Email Address: \_\_\_\_\_

Pharmacy number for prescription call in: \_\_\_\_\_

**I understand that this office will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond this office's control.**

**I understand and agree to the above e-mail policy.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date