ANCHORAGE NEUROSURGICAL ASSOCIATES, INC.

REQUEST AND CONSENT TO ELECTRONIC COMMUNICATIONS REGARDING PATIENT

I am the parent, legal guardian, or attorney-in-fact for the below-named Patient of Anchorage Neurosurgical Associates, Inc. ("ANAI"). I hereby request and consent to have the Patient's physician, non-physician provider, and other staff at ANAI communicate with me by email regarding various aspects of the Patient's medical care, which may include, but shall not be limited to, test results, prescriptions, appointments, and billing. I understand that email is not a confidential method of communication and may be insecure. I further understand that, because of this, there is a risk that email(s) regarding the Patient's medical care might be intercepted and read by a third party.

I understand that although ANAI tries to read and respond promptly to all emails from patients, ANAI cannot guarantee that any particular email will be read and responded to within any particular time period. I understand that for this reason I should not use email for medical emergencies or other time-sensitive matters.

I understand that I may revoke this consent at any time by delivering written notice to ANAI.

Name of Patient: _____

Name of Parent/Legal Guardian/Attorney-in-Fact: _____

Date: _____ _____

Signature of Parent/Legal Guardian/Attorney-in-fact

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