_____

# Physician or Specialty

## E-Mail Consent Form

| | |
|---|---|
| Patient Name: | Email: |
| SSN or Account Number: | Date of Birth: |

## *Please read the following statements carefully:*

1. RISKS OF USING E-MAIL. Transmitting patient information by E-mail has many significant risks that you should consider before asking us to use E-mail as a means of communicating your personal health information. These risks include, but are not limited to, the following:

    a. E-mail can be circulated, forwarded and stored in numerous paper and/or electronic files without your knowledge;
    b. E-mail can be sent immediately worldwide and received by large numbers of unintended individuals;
    c. E-mail addresses can be misaddressed causing the information to be sent to the wrong individuals; or
    d. E-mail can be intercepted, changed and redistributed to others.

2. OUR CONDITIONS FOR USE OF E-MAIL. We will use reasonable means to protect the security and confidentiality of E-mail sent and received. However, because of the risks, some of which are outlined above, we cannot guarantee the security and confidentiality of E-mail communication, and will not be responsible for improper disclosures of your health information. Accordingly, you must consent to the use of E-mail for sending your personal health information. Consent to the use of E-mail includes your agreement with the following conditions:

    a. All E-mails concerning your diagnosis or treatment will be printed out and made part of your medical record. Because they are a part of the medical record, other individuals authorized to access the medical record will have access to these E-mails;
    b. We may forward E-mails internally to our staff and agents as necessary for diagnosis, treatment, reimbursement, and other appropriate purposes. We will not, however, forward E-mails to independent third parties without your prior written consent, except as authorized by law;
    c. We cannot guarantee that any particular E-mail from you will be read and responded to within any particular time. Thus, you should not use E-mail for medical emergencies or other time sensitive matters;
    d. If your E-mail requires or invites a response from us, and you have not received a response from us within a reasonable period of time, it is our responsibility to follow-up to determine whether the intended recipient received the E-mail and when the recipient will respond;
    e. You should not use E-mail for communication of sensitive medical information including, without limitation, sexually transmitted diseases, HIV/AIDS, mental health conditions, substance abuse or other developmental disabilities;
    f. You are responsible for informing us of any type of information that you do not want sent by E-mail;
    g. We shall not engage in unlawfully practicing medicine across state lines; and
    h. We will not be responsible for the occurrence of any of the items set forth in Paragraph 1 above.

**BY SIGNING THIS FORM, I HEREBY ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THIS CONSENT TO USE AND/OR DISCLOSE MY HEALTH INFORMATION VIA E-MAIL. I UNDERSTAND THAT RISKS AND CONSENT TO THE CONDITIONS OUTLINED HEREIN AND ANY OTHER INSTRUCTIONS OR CONDITIONS _____ MAY IMPOSE CONCERNING THE USE OF E-MAIL COMMUNICATIONS.**

**(Specialty Name)**

_____ _____

Signature of Patient or Patient's Representative Date

_____

Printed Name of Patient's Representative (if applicable)

_____

Representative's Relationship to Patient (if applicable)