|  |
| --- |
| **Patient Email Consent Form** |

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EmaiI Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thorp Bailey Weber Eye Associates cannot guarantee, but will use reasonable means to main­tain the security and confidentiality of email sent and received. We take appropriate precautions when transmitting email to avoid unintentional disclosures, such as verifying your e-mail ad­dress for accuracy before sending. The Practice is not liable, however, for improper disclosure of confidential information that is not caused by our intentional misconduct.

**The Risks of Using Email**

Transmitting patient information by email can be risky. Please consider the following possibilities before agreeing to communicate with us this way, or giving consent to email personal health information to other individuals, healthcare providers, etc. For example, both secured and unse­cured email messages can be intercepted, circulated, altered, forwarded, stored or used without authorization or detection. In addition, messages may be misaddressed, read by employers and online service providers, easily falsified, retained after deletion, used to introduce viruses, or used as evidence in court.

**Still Want To Use Email?**

If you want to use email to communicate with us we have some final instructions.

* We cannot guarantee your emails will be read promptly, so please do not use email for urgent matters.
* Be sure to follow-up with us by phone if you are expecting a return response from us and do not receive one within 2 business days.
* Please notify us promptly if your email address has changed.
* Be aware that most emails from patients become a part of their health record.
* Do not use email to share sensitive medical information, such as communications about AIDS/HIV or mental health conditions, sexually transmitted diseases or substance abuse.

I understand the risks associated with communicating by email between this Practice and me, and give my consent for the practice to email my personal health information  unsecured  secured.

If I have any questions, I will contact the Practice Privacy Officer.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal Representative:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Distribution of Copies: Original to Patient's Health Care Record, Copy to Patient.*