Patient Request for Email Communications

Communications over the Internet and/or using the email system are not encrypted and are inherently insecure. There is no assurance of confidentiality of information when communicated this way. Nevertheless,you may request that we communicate with you via email. To do so, you must complete this form and return it to your health care provider's office.

Please be advised that:
(1) This Request applies only to the health care provider or office that you indicate below. If you would like to request to communicate via email with another health care provider or office, you must complete a separate Request for that office.
(2) Your health care provider will not communicate health information that is specially protected under state and federal law (e.g., HIV/AIDS information, substance abuse treatment records information, mental health information) via email even if we agree to communicate with you via email.
(3) Your Request will not be effective until you receive and respond appropriately to a test email message from your doctor. Please select the test question you want to use below, and provide us with your answer.

Please provide the following information:
Patient Name: ________________________ Date of Birth: _________
Phone number: _______________________
Address: ____
Please specify the email address to which communications should be addressed:
____
Please specify the health care provider or office from which you are requesting email communications:
____
Please select the question you want to use (by checking the one of the boxes below) for your test email and provide your answer.
o The last four digits of my Social Security Number: _______________
o My mother's maiden name: _______________
o My middle name: _______________
o The street number of my residence: _______________
Please initial each blank and sign below:
____ I certify the email address provided on this Request is accurate, and that I, or my designee on my behalf, accept full responsibility for messages sent to or from this address.
____ I have received a copy of the IMPORTANT INFORMATION ABOUT PROVIDER/PATIENT EMAIL form, and I have read and understand it.
____ I understand and acknowledge that communications over the Internet and/or using the email system are not encrypted and are inherently insecure; that there is no assurance of confidentiality of information when communicated this way.

____ I understand that all email communications in which I engage may be forwarded to other providers, including providers not associated with my doctor, for purposes of providing treatment to
me.
____ I agree to hold my doctor and individuals associated with him/her harmless from any and
all claims and liabilities arising from or related to this Request to communicate via email.

____
Signature of patient or personal representative

____
Date

____
If personal representative, authority to act on behalf of patient