E-MAIL CONSENT FORM FOR NON-SECURE E-MAIL

STRASH FOOT & ANKLE CARE

Patient Name: _____ Date of Birth: _____

Patient E-mail Address: _____

• **Strash Foot & Ankle Care cannot guarantee the security and confidentiality of an e-mail transmission.** Employers and on-line services have the right to access and archive e-mail transmitted through their systems. If your e-mail is a family address, other family members may see your messages. therefore, please be aware that you e-mail at your own risk. Because of the many interne and e-mail factors beyond our control, we cannot be responsible for misaddressed, misdelivered or interrupted e-mail. Your health care provider is not liable for breaches of confidentiality caused by yourself or a third party.

• E-mail is best suited for routine matters and simple questions. You should not send us e-mail for urgent or emergency situations or for matters requiring an immediate response. Your provider will attempt to read and respond promptly to e-mail but cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Time sensitive issues should be taken care of by telephone.

• Please do not use e-mail for communications regarding sensitive health information, such as sexually transmitted diseases, AIDS/HIV, mental health or substance abuse.

• Please include your full name, birthdate and telephone number in all e-mails. List the subject of your e-mail in the "Subject" line of your message.

• All e-mails between you and your provider regarding diagnosis or treatment will be printed and made part of your permanent health information.

• Your provider may forward your e-mail to other staff members as necessary for response. However, your e-mail will not be forwarded outside of our practice without your authorization.

• In order to prevent the introduction of computer viruses into our system, do not send attachments to us in your e-mail.

• You are responsible for protecting your password or other means of access to e-mail.

Signature of Patient: _____ Date: _____

Witness: _____ Date: _____