Attachment A

E-Mail/Electronic Communication Consent

NSLIJ discourages the use of email to communicate about your medical matters because it is not a secure method of communication, information could potentially be sent to the wrong person, may not be the most timely method of communication and it is dependent on technology which may or may not work all time. However, if you chose to communicate with your provider regarding email, NSLIJ asks that you acknowledge and consent to the following:

I understand that e-mail communication should not be used for emergencies or for communicating time sensitive information. In the event of a medical emergency I should contact 911 or go to the nearest Emergency Department. To communicate emergent or time sensitive information I should directly contact the office of the healthcare provider.

I understand that e-mail communication will be processed during routine business hours. In the event I do not receive a response, I understand that I should contact the office directly.

I understand that due to situations outside of the control of the physician, clinicians and office practices, internet and email service may be interrupted or not work at any given time. The physicians, clinicians and office practices are not responsible for technical failures. Again, if you do not receive a response to your email, please call the office directly during business hours.

I will not share, distribute, release or sell my healthcare provider's e-mail address to anyone.

I understand that email communication is not a substitute for medical care and evaluation. I must arrange for an office appointment to assure appropriate care.

I understand that I am to provide my full name and contact information in all e-mails, e.g., full name, address, phone number(s) on each email.

I understand and accept that my provider may route my e-mail to other members of the staff for informational purposes or for expediting a response. I authorize my provider to send and designate staff to receive and read my e-mail.

I acknowledge that commonly used e-mail services are not secure and fall outside the security requirement set forth by the Health Insurance Portability and Accountability Act for the transmission of protected information. Therefore, I understand there is a risk that my health information may be obtained by others not affiliated with my provider. I authorize my provider to transmit my personal health information via email even though email may not be secure and private and may be subject to loss or exposure.

I acknowledge and accept that my healthcare provider can terminate e-mail communication services at any time.

I understand that I am responsible for notifying the physician if I chose to discontinue email communication or if my email address has changed.

_____		_____	
Patient/Agent/Relative/Guardian* Signature	Date	Print Name	Relationship if other than patient
_____		_____	
Interpreter, if applicable (Signature)	Date	Print Interpreter Name or Telephonic Interpreter's ID	
_____		_____	
Witness to signature (Signature)	Date	Print Name	

* Requires signature of the patient or legally authorized representative (i.e., court appointed guardian, health care proxy, parent of a minor, etc.)