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Patient Authorization For E-mail Communication

I hereby give consent to my physician_________________(insert name of physician or practice) to communicate with me via e-mail and agree that:

- I will use e-mail for non-emergency purposes only;
- I have received a copy of this office's e-mail policies and have had a chance to ask questions about them;
- I understand that e-mail communications from my physician are not encrypted and that the security of such e-mails cannot be guaranteed;
- I understand that all e-mail communications will be filed in my permanent medical record; and
- I agree to inform this office in writing if my e-mail address changes.

Print Full Name____

My current e-mail address____

Signature___________________________

Witness____________________________ Date___________________________