UNIVERSITY OF ROCHESTER
MEDICAL CENTER

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PATIENT E-MAIL CONSENT FORM

Patient name: _____
Patient MRN: _____
Patient E-mail: _____
Provider: _____
Provider E-mail: _____
Personal Representative*:
Name: _____
Relationship: _____
E-Mail: _____

** see HIPAA Policy 0P16 Personal Representative*

1. RISK OF USING E-MAIL

Transmitting patient information by E-mail has a number of risks that patients should consider. These include, but are not limited to, the following:

a) E-mail can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
b) E-mail senders can easily misaddress an E-mail.
c) Backup copies of E-mail may exist even after the sender or the recipient has deleted his or her copy.
d) Employers and on-line services have a right to inspect E-mail transmitted through their systems.
e) E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
f) E-mail can be used to introduce viruses into computer systems.

2. CONDITIONS FOR THE USE OF E-MAIL

The Provider cannot guarantee but will use reasonable means to maintain security and confidentiality of E-mail information sent and received. The Patient and Provider must consent to the following conditions:

a) E-mail is not appropriate for urgent or emergency situations. The Provider cannot guarantee that any particular E-mail will be read or responded to.
b) E-mail must be concise. The Patient should schedule an appointment if the issue is too complex or sensitive to discuss via E-mail.
c) E-mail communications between patient and provider will be filed in the Patient's permanent medical record or departmental file.
d) The Patient's messages may also be delegated to another provider or staff member for response. Office staff may also receive and read or respond to patient messages.
e) The Provider will not forward patient-identifiable E-mails outside of the URMC healthcare system without the Patient's prior written consent, except as authorized or required by law.
f) The Patient should not use E-mail for communication regarding sensitive medical or financial information.
g) It is the Patient's responsibility to follow up and/or schedule an appointment if warranted.
h) Recommended uses of patient-to-provider e-mail should be limited to:
    a. Appointment requests
    b. Prescription refills
    c. Requests for information
    d. Non-urgent health care questions
    e. Updates to information or exchange of non-critical information such as routine laboratory values, immunizations, insurance changes, financial eligibility information, etc.

3. INSTRUCTIONS

To communicate by E-mail, the Patient shall:

a) Avoid use of his/her employer's computer.
b) Put the Patient's name in the body of the E-mail.
c) Put the topic (e.g., medical question, billing question) in the subject line.
d) Inform the Provider of changes in the Patient's E-mail address.
e) Take precautions to preserve the confidentiality of E-mail and any attached documents.
f) Contact the Provider's office via conventional communication methods (phone, fax, etc.) if the patient does not receive a reply within a reasonable period of time.

4. PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of E-mail between the Provider and me. I consent to the conditions and instructions outlined here, as well as any other instructions that the Provider may impose to communicate with me by E-mail. I agree to use only the pre-designated e-mail address specified above. Any questions I may have had were answered.

_____
Patient or Personal Representative signature

Date _____

_____
Provider signature

Date _____

Original – to be retained in Medical Record
Copy – to be given to the Patient/Personal Representative

SH 42
Rev. 04/06