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Consent for Communication via Email

Provider-Patient

I, _(Patient Name)_, herby consent to have my physician, communicate with me or members of his/her staff when appropriate or other physicians, nurse practitioners, and pharmacists via e-mail regarding the following aspects of my medical care and treatment: (Test results, prescriptions, appointments, billing, etc).

I understand that e-mail communications between my physician and me or members of my physician's office staff or between my physicians, another physician, nurse practitioner and pharmacists regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties.

I understand that in an urgent or emergent situation I should call my provider or go to the Emergency Room and not rely on e-mail.

Patient's Name: _____
Print your Full Name

Signature: _____ Date: _____
Patient's Signature