ARTHRITIS CONSULTANTS, PC
CONSENT FOR ELECTRONIC COMMUNICATION

Patient Name: _____ Date of Birth: _____

I understand that electronic communication should NOT be used in the case of a need for emergency care.

I understand that refusal of this consent for electronic communication will not affect my ability to obtain treatment.

I request electronic communication via Email that contains a link to protected health information in my health record maintained or created by the Practice named above.

I understand that by providing an Email Address, I attest that I control access to its information.

I understand that by providing an Email Address and creating a Secure Email account, I am agreeing not to share my password with others where unwanted access may occur.

I understand that Practice will not solicit either my Email Address password or my Secure Email account password. These passwords are my sole responsibility for up-keep. If I forget my password, I will be required to know my registration information; i.e., secret question(s), to continue.

I understand that I may revoke this consent at any time by providing the Practice with a verification of my identity and requesting that my current email address be removed from the system. This will not apply to communications that have been sent prior to the revocation date.

The information authorized for release also may include drug/alcohol abuse treatment information. This category of medical information is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit anyone receiving this information from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. As a result, by signing below I specifically authorize any information included in my health information to be released via electronic communication. I understand the information sent via electronic communication may include information that may indicate the presence of a communicable disease or non-communicable disease.

I understand that this service of electronic communication is offered solely on the discretion of the OU entity named above and may be withdrawn to any patient at any time.

I agree that I will read and abide by all the Terms of Use at the Practice Secure Email Login Page prior to accessing email from the Practice. I understand this is not a request for release of my medical records.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Name of Patient or Personal Representative Address

_____ _____
Description of Personal Representative's Authority Telephone