

## Email Policy and Consent Form

Please note that email will be used as a tool to provide patients reminders, resources and electronic documents (i.e. requisitions). Email may be used to schedule appointments in the future.

Email is not to be used in place of an appointment with the doctor. **Urgent matters should not be managed through email and in the event of a medical emergency, patients should go to their nearest emergency department.**

Emails will be checked Monday-Friday from 9 am – 5 pm and will not be checked over the weekend, vacations or statutory holidays. Every effort will be made to respond to emails quickly. Please expect a response time of up to 5 business days. If the patient has not received a response within a reasonable time period, it is the patient’s responsibility to follow up to determine whether the intended recipient received the email and when the recipient will respond.

Every effort will be made to keep emails confidential, however please note the insecure nature of online communication such as email. It is the responsibility of the patient to prevent unauthorized access to his or her own email system. Please note that the email account will be checked by the office front desk staff and by the doctor.

Email should not be used to discuss sensitive matters. The patient is responsible for informing the office of any types of information the patient does not want to be sent by email. Please be aware that email communication may become part of each patient’s medical record.

I agree to indemnify and hold harmless the Physician, her medical practice and employees from and against all losses, expenses, damages and costs, including reasonable attorney’s fees, relating to or arising from any information loss due to technical failure, my use of the Internet to communicate with the office, and any breach by me of these restrictions and conditions.

*I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between the Provider and me, and consent to the conditions herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that Provider may impose to communicate with patients by email. I understand that permission to use online communication may be withdrawn for failure to abide by the terms and conditions of use. Any questions I may have had were answered.*

Name \_\_\_\_\_  
(Please print)

Date \_\_\_\_\_

Signature \_\_\_\_\_