

ELECTRONIC COMMUNICATION CONSENT

Electronic communication such as email offers an easy and convenient way for patients and doctors to communicate. In many circumstances, it has advantages over office visits or telephone calls, but here are important differences. E-mail is not the same as calling our office; there is no person at the other end of the call – just a computer. You can't tell for certain when your message will be read, or even if your doctor is in the office or on vacation. Nonetheless, we believe that the ease of communication e-mail affords is a benefit to patient care. It will further assist us if you could identify the nature of your request in the subject line of your message. Below are our rules for contacting us using e-mail.

E-mail is never, ever, appropriate for urgent or emergency problems! Please use the telephone or go to the Emergency Department for emergencies.

E-mail is great for asking those little questions that don't require a lot of discussion. Appropriate uses of e-mail also include prescription refill requests, referral and appointment scheduling requests and billing/insurance questions.

E-mails should not be used to communicate sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.

E-mail is not confidential. It is like sending a postcard through the mail. Our staff may read your e-mails to handle routine, non-clinical matters. You should also know that if sending e-mails from work, your employer has a legal right to read your e-mail.

E-mail may become a part of the medical record when we use it; a copy may be printed and put in your chart.

E-mail is not a substitute for seeing us. If you think that you might need to be seen, please call and book an appointment!

E-mails may be forwarded to our staff for handling, if appropriate.

Finally, either one of us can revoke permission to use e-mail electronic communications at any time, which will impact future and not past communications.

I have read the above information and understand the limitations of security on information transmitted. I understand that my doctor may not be able to communicate with me electronically about my specific condition if I live outside of the state in which my doctor is licensed. *(Please initial consent option below)*

Email Communications:

____ **Yes**, I have read this consent to E-Mail communication and want to communicate with my doctor/student/staff electronically.

____ **No**, I do not consent E-mail communication and do not want to communicate with my doctor/student/staff electronically.

Southwest College of Naturopathic Medicine (SCNM) offers appointment reminders via e-mail and text message. *(Please initial consent option below.)*

E-mail Reminders:

____ **Yes**, I authorize SCNM to send appointment reminders electronically via E-mail to the e-mail address(s) listed below. I understand that my contact information will not be sold to third parties.

____ **No**, I do not authorize SCNM to send appointment reminders electronically via E-mail.

(continued on reverse)

Text Message Reminders:

____ **Yes**, I authorize SCNM to send appointment reminders electronically via text message to my mobile phone. I understand this service is offered free of charge, however standard text message rates from my mobile carrier may apply. Please activate text message reminders for the following patient and mobile phone listed below. I understand that my contact information will not be sold to third parties.

____ **No**, I do not authorize SCNM to send appointment reminders via text message. Continue receiving reminders via personal phone call.

Join Our Mailing List:

SCNM offers electronic and print notifications including but not limited to health programs, event notifications, discounts, and newsletters.

____ **Yes (OPT IN)**, please notify me of health programs, event notifications, discounts, and newsletters using electronic and print notifications.

____ **No (OPT OUT)**, Please do not notify me of health programs, event notifications, discounts, and newsletters.

Please complete all information below:

E-mail Address

Alternate E-mail Address

Mobile Number

State of Residence

I have fully read and understand the above consent and authorizations.

Print Patient Name

MR Number (Office Use Only)

Patient or legally authorized individual signature

Date

Printed legally authorized individual signature

Relationship (self, parent, legal guardian,
personal representative, etc.)

The information contained in this e-mail is confidential, privileged, or otherwise protected from disclosure. It is intended only for the use of the authorized individual as indicated in the e-mail. Any unauthorized disclosure, copying, distribution or taking of any action based on the contents of this material is strictly prohibited. Review by any individual other than the intended recipient does not waive or give up the physician-patient privilege. If you have received this e-mail in error, please delete it immediately.

SOUTHWEST COLLEGE OF NATUROPATHIC MEDICINE & HEALTH SCIENCES

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