# CLARKSBURG MEDICAL GROUP
# EMAIL CONSENT

If you choose to use email at our clinic, signing this consent form provides the clinic with your permission to communicate with you via email and is required before we will respond to your email or send you email for the first time. This consent can be withdrawn at any time by contacting the clinic by phone or in person.

This clinic supports the use of email for the purpose of communicating with our patients regarding their clinical care. A care provider may agree to communicate with you using email but is not required to do so. You may choose to communicate with the clinic using email but you are not required to do so.

If you choose to communicate with the clinic using email, you should be aware that email messages you send to or receive from the clinic:

* may not be secure. The clinic cannot guarantee the security of any email message transmitted outside of our email system;
* may exist as an electronic or paper record within the clinic indefinitely.

For these reasons, if you use email to communicate any information, including personal health information, to the clinic, or to receive any information, you are hereby accepting the inherent **risk of this information being compromised**.

THE CLINIC CANNOT GUARANTEE THAT YOUR EMAIL WILL BE RECEIVED, READ OR RESPONDED TO WITHIN ANY PARTICULAR PERIOD OF TIME. YOU MUST NOT COMMUNICATE WITH THE CLINIC VIA EMAIL FOR MEDICAL EMERGENCIES OR OTHER TIME-SENSITIVE MATTERS.

## TERMS OF USE

I understand that it is my responsibility to monitor email received at the indicated email address(es) and to advise the clinic in writing if any email address changes or should no longer be used by the clinic for email communications with myself. I understand that only this email address will be used by the clinic for communication to me.

I understand that the clinic cannot guarantee the security of email messages that I send to or receive from the clinic.

I agree not to use email to communicate emergency or urgent information about myself and understand that the clinic does not guarantee the receipt or review of any email messages that I may send to the clinic.

I understand and agree that individual care providers may make decisions about my treatment based on information I provide through email and that this information may form part of my health record.

I understand that individual care providers may stop using email for clinical communication purposes at any time, at which point s/he will inform me in writing or notify me about this decision at the time of my next appointment.

I understand that I may stop using email for clinical communication purposes at any time, at which point I will notify the clinic in writing of my decision to stop using email for these purposes. I understand that this consent remains effective unless and until it is withdrawn.

I understand and agree that if my physician is referring me to another healthcare professional, my contact information, which includes phone numbers and email address will be included in the referral letter.

**(Please check off your doctor)**

**Dr Euler/Allan** _______ **Dr Elkhuizen**_________ **Dr Murphy** ________

MY NAME _______________________________________________ DATE ______________

EMAIL ADDRESS _____________________________________________________________

**YES** I give consent ___________ **NO** I do not give my consent__________

SIGNATURE _________________________________________________________________