**Consent-Electronic Transmission of Protected Health Information (PHI)**

I ……………………………………………………., give Dr Manaf Ahmad my consent to send (please check the appropriate box):

O Medical Records

O Protected Health Information

O Educational materials

for (name of patient)………………………………………………….. to the following fax/e-mail address(es):

………………………………………………………………………..

………………………………………………………………………..

I acknowledge that I have the legal rights to obtain medical records, I also understand that:

1. I have the right to revoke this authorization, in writing, at any time.
2. E-mail is not appropriate for urgent or emergency situations.
3. Health care providers cannot guarantee but will use reasonable means to maintain security and confidentially of electronic mail (E-mail) information sent and received.

Furthermore, I accept the risks associated with the use of unsecure E-mail communications.

I understand that, as with all means of electronic communication, there may be instances beyond the control of the family and the health care provider where information may be lost or inadvertently exposed, such as during technical failures, acts of God, acts of war, and so forth. By signing this form, I acknowledge the privacy risks associated with using E-mail and authorize health care providers to communicate with me or any minor dependent for purpose of medical advice, education, and treatment

Signature ……………………………………………….

Date ……………………………………………………….

Logo

Description automatically generatedLogo

Description automatically generated with medium confidence